

Talking about menopause: Exploring the lived experience of menopause for nurses

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Abstract

As the participation of women in the workplace has grown, so too has the need to live through menopause in a more public way. Previously managed in private, many women now experience (often visible) menopausal changes at work, frequently in front of others. Even though it will affect most women at some point in their lives, menopause is still not widely spoken about. This lack of open discourse has allowed negative narratives around body image, ageing, emotional stability and competence in the workplace to linger unchallenged.

With a predominantly female workforce, a large proportion of whom are aged between 45 and 55 years (the timespan commonly associated with menopause), there was little known about the experience of menopause within the health sector in New Zealand. The aim of this qualitative study was to explore how these women experienced menopause. Eleven nurses working at Christchurch Hospital shared their lived experiences of menopause in semi-structured, in-depth interviews. A thematic analysis revealed that due to the continued stigma around menopause, the participants feared being outed as a menopausal woman, particularly in the workplace where professionalism and pride in “being a nurse” was important to them.

Feelings of embarrassment and shame, especially where the women were unable to conceal the outward bodily signs of menopause, challenged them to redefine not only their own sense of self, but also to understand that others may view them differently because of this. Relationships with colleagues changed through this period as both the women and their co-workers learned to navigate what is, to many, considered a taboo subject. Outside of work, responsibilities for ageing parents, partners and children with varying levels of dependence competed with the effects of menopause, testing the coping skills of women already under stress. Unsurprisingly this resulted in many of the women questioning the gendered expectations of others while exploring strategies to improve their own situation, both within their workplace and the wider social context within which they lived.

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Chapter One - Introduction

French Physician Charles de Gardanne is widely credited with naming the menopause (la ménépausie) in 1816, albeit calling it a “... *nervous disorder manifested in various physical and mental illnesses*” (cited in Roush, 2011, p6). The term came from the ancient Greek words “men”, meaning month (mene also means moon - at that time the months were measured by the moon) and “pausis” which means to cease or stop (Dictionary.com, 2016).

As knowledge about the physical changes that occurred during menopause increased, medical professionals increasingly viewed it as something to “cure”. Indeed the advent of hormone replacement therapy in the 1960s saw some interesting claims made in relation to the difference it made, not just to women, but to wider society. Dr Robert A Wilson, (a New York Consulting Obstetrician and Gynaecologist) was a particularly strong advocate for “curing” menopause due to his belief that:

There is ample evidence that the course of history has been changed not only by the presence of estrogen, but by its absence. The untold misery of alcoholism, drug addiction, divorce and broken homes caused by these unstable, estrogen-starved women cannot be presented in statistical form.

(Wilson & Wilson, 1963, p355)

A more contemporary approach views menopause as a mix of physical manifestations and individual factors that each woman brings to their experience within their own time and place. Such influences as personal values and attitudes, cultural and religious beliefs, social pressure around how women look, together with views on ageing, all influence how women experience this stage of their life (Hoga et al., 2014; Beasley, 1999; Marnocha et al., 2011).

Although often used interchangeably, the terms menopause and perimenopause do refer to distinctly different things. Defined as the cessation of menstruation, menopause occurs in the western world at an average age of 51 years (Rubenstein, 2014; Hoga et al., 2014; Griffiths, 2013). This has not changed over the last 300 – 400 years, despite life expectancy increasing during that time (The American Congress of Obstetricians and Gynaecologists, 2011). Perimenopause refers to the menopausal symptoms often experienced by women for between 5 and 10 years before their final period, also called the menopause transition (Australasian Menopause Society, 2016). This research will use the term “menopause” to reflect the broader context of the menopause transition as well.

Let's talk about menopause

Despite the fact that it will affect most women at some point in their lives, menopause is still not widely spoken about in the workplace or in the media. In the United Kingdom recently, following the release of a report into women's health (Davies, 2015), the Chief Medical Officer, Professor Dame Sally Davies, took the unusual step of speaking publically about menopause saying:

The menopause is a natural part of life, but it can feel like a great taboo. It is inexcusable that women who are experiencing menopausal symptoms should feel unable to discuss how they are feeling at work.

(BMS British Menopause Society, 2015, News, para 6)

For many women, myself included, negative connotations surround the concept of menopause, and in part, this may be due to the lack of open discussion around it. When I first considered exploring menopause at work as a possible topic for a thesis, I discussed this individually with several friends who were approaching or in the midst of this life stage. It was interesting to me that their responses varied from excitement at the prospect of having an increased source of knowledge within their midst, to horror that I would even contemplate raising this, especially when the workplace was full of men (why

would I want to draw attention to something so personal in their presence?). As I've continued to research menopause with a focus on women working in health, I have had a senior clinician confess her use of hormone therapy, quickly followed by a complex justification for this. I have also had a senior male nurse tell me that he can always tell the nurses who are menopausal as they are the ones sitting in the corner of the room waiting to bite his head off. It quickly became clear to me why women approached menopause with trepidation.

The New Zealand context

To understand the lived experience of menopause for women working in the health sector it is vital that we begin to have these conversations around menopause in the workplace. Nursing requires constant interaction with others, so the experience of working through menopause presents some challenges for those encountering its effects. Reported difficulties in the workplace have included being unable to concentrate, tiredness (often due to difficulty sleeping), managing heavy bleeding and hot flushes (Griffiths et al., 2010; Morris & Symonds, 2004; Dillaway, 2011). All of these things can affect a woman's confidence in her ability to do a job, even more so when that job occurs under the watchful gaze of others.

The health workforce in New Zealand is predominantly female and is also ageing, especially in the areas of nursing, midwifery and the unregulated¹ workforce. In 2014 there were 12,646 female nurses aged between 45 and 55 years (25% of the total nursing workforce) (The Nursing Council of New Zealand, 2015) and 976 midwives (32% of the midwifery workforce) (Midwifery Council of New Zealand, 2014). Similarly, 50% of female doctors are aged between 40 and 60 years of age (New Zealand Medical Council, 2014)

¹ Those health care workers not subject to regulation under health legislation e.g. allied health assistants, hospital aids, and support workers.

and 54% of the unregulated workforce (84% of which are women) are aged between 45 and 65 years (Twaddle & Khan, 2014).

With an ageing population resulting in a growing demand for healthcare, the New Zealand health system will need to increasingly rely on a workforce that are experiencing the menopause years, and it will be important to keep them engaged in the workforce for as long as possible. Exploring the menopause experience of women working in the health sector will provide some guidance for issues that could support their well-being and productivity at work (and may also be beneficial to the wider health workforce). Literature shows that other countries are starting to address menopause at work as an occupational health and wellness issue (Griffiths, 2013; Jack et al. 2016; Mannetje et al. 2009). This study may highlight if there is a need for New Zealand to look at this as well.

Thesis aims and structures

This thesis aims to explore how and why nurses experience menopause, as they do, and will enable further consideration of what matters in the ongoing well-being and productivity of menopausal women at work. It is likely that physical, psychological, emotional and broader socio-cultural influences will have influenced how these women interpret their reality (Griffiths, MacLennan & Hassard, 2013; Simon & Reape, 2009). Analysis of those different perceptions and understandings, enabling the development of “...a theoretical understanding of the underlying structures of beliefs” (Green & Thorogood, 2014, p97) may potentially provide an increased awareness of the impact menopause has on the experience of women who work in the health sector. The following chapters will explore the findings of this thesis.

Chapter Two first outlines the literature on menopause, including the impact of medicalisation and the conflict it raises for women who may not want “treatment” but still seek relief from physiological symptoms. The next section discusses feminist discourses and the embodiment of menopause, highlighting

the many “choices” available to women in choosing how they approach their menopause experience. In talking about a “feminist approach”, my intention is to encompass that branch of feminism that subscribes to the notion of menopause as a “natural” phenomenon. Consideration of the influence of culture, not just related to indigeneity but broader cultural influences as well, follows. Finally this chapter considers literature relating to menopausal women at work, identifying the paucity of local research in general and within the health sector specifically. Chapter Three describes the methodology and methods used to support the research process. A section on reflexivity acknowledges my role in the research process as both a co-constructor of knowledge with the interviewees and also as a menopause “insider”.

Chapters Four, Five and Six explore, develop and discuss the findings that emerged from my interviews. Chapter Four discusses the embodiment of menopause through the theme of a recalcitrant body, examining how the women manage their menopausal bodies within a workplace that is not always inclusive of difference. Drawing on Hochschild’s (1983) concept of emotional labour and Goffman’s (1959, 1990) impression management, Chapter Five examines how the women construct a menopausal identity, something that appeared to underpin the women’s struggle to maintain their professionalism at work.

In the final findings chapter, I draw on Hochschild and Machung’s (2003) “second shift” (this refers to the unpaid work many women do at home and in relation to children outside of their paid work) and Miller’s (1981) “sandwich generation” (being responsible for children while also having increasing obligations for ageing parents) to examine the extra responsibilities and expectations these women faced outside of work.

Chapter Seven draws together the key findings of the research, and considers the implications for women working through menopause and how this impacts on their professionalism and pride in “being a nurse”.

Chapter Two - Background and Literature Review

As the participation of women in the workplace has grown, so too has the need to live the menopausal journey in a more public way. How women and their workplaces manage this is still a relatively new area of research. Often studies of menopause have taken an epidemiological viewpoint, concentrating on menopausal symptoms, their measurement and treatment. Research that focuses on the lived experience of women navigating their menopause years is less prevalent. In this chapter, I have firstly reflected on the medicalisation of menopause and research that examines the impact of this. I have then considered literature exploring the role of feminist discourses and the embodiment of menopause. Next, I examined research on how cultural and social filters may influence women's lived experience of menopause. I then conclude this literature review by examining research that explores the experience of menopausal women in the workplace.

The medicalisation of menopause

As described by Maturo (2012), the process of medicalisation is where “some aspects of human life come to be considered as medical problems, whereas before they were not considered pathological” (p122). During the 1960s there was a strong focus on a medicalised approach to menopause, seeing it as a “deficiency disease” within women (Wilson, 1964, p20). Such views reflected the value of women in society at that time, providing a timely reminder that the prevailing social and cultural context influence our experiences of menopause, and as such will vary over time. A good example of this is the following quote from Dr Robert A Wilson, (a New York Consulting Obstetrician and Gynaecologist) writing in an editorial for the Delaware Medical Journal, in January 1964:

A girl becomes a woman when estrogen and progesterone arrive. When they depart, she is a woman by courtesy only - in reality a castrate, condemned by tradition and a mystique that surround this time of her life in an almost impenetrable cloak. ... In the past, because the menopause happened to every woman, it was generally thought to be normal. ... We know that menopausal women are not normal; they suffer from a deficiency disease with serious sequelae and need treatment.

(Wilson, 1964 p20)

Dr Wilson then went on to assert his support for (the earliest form of) hormone replacement therapy, describing the impact of its daily ingestion as being "...the essential difference between a life partly lived or a full one - a body and mind of multiple divisions or homeostasis, the complete woman" (p21). He was convinced that given the choice most women would "...elect to avoid their probable fate - hypertension, arteriosclerosis, flabby breasts, dowager's hump, and atrophic genitals", and accept their medicine (p359).

At the same time as Dr Wilson was promoting his message of women's deterioration at menopause, the emerging women's movement saw women questioning what it meant to be a woman and what their role in society was. In an article that addressed the feminist response to Dr Wilson's book "Feminist Forever", Houck (2003) outlined the divergent views among those in the women's movement concerning menopause viewed from Dr Wilson's "deficiency disease" model. Many women had mixed feelings as to whether they should embrace the medical profession's focus on "their normal physiological processes", contemplating whether the symptoms of menopause were merely a product of a "defective physiology" or constructed by "a sexist society", and whether therapeutic hormone treatments "help or hinder the cause of women's liberation" (Houck, 2003 p2).

Underpinning these discussions was the broader feminist belief that women should be involved in any decision regarding their health, achieving this through educating themselves about their bodies and how they functioned.

The following passage from the preface of the Boston Women's Health Collective book 'Our Bodies, Ourselves' encapsulated this approach.

The experience of learning just how little control we had over our lives and bodies, the coming together out of isolation to learn from each other in order to define what we needed, and the experience of supporting one another in demanding the changes that grew out of our developing critique - all were crucial and formative political experiences for us.

(Boston Women's Health Collective, 1973 para 9)

It is this broader view that Houck (2003) identified as moving beyond the demarcated boundaries of feminist discourse, affecting menopausal women who might not otherwise have associated themselves with a feminist point of view. However even the Boston Women's Health Collective were not immune to changing views on medical intervention during menopause, with Houck (2003) noting that "while the 1973 version [of the Boston Women's Health Collective book] embraced ERT², the 1976 version was more circumspect" (p13). The dilemma for feminists remained whether to embrace medical advances - which despite positioning menopause as something clinicians could cure, also provided relief from debilitating symptoms - or whether to view menopause as a natural transition that had a social meaning and significance as well. Houck (2003) explained that as feminists began to appreciate that menopause was not only affected by a physical transition but a social one as well, the focus changed to considering a solution that required changes to both how women viewed their ageing bodies and how society viewed women.

² HRT is sometimes referred to as estrogen replacement therapy (ERT), because the first medications that were used in the 1960s for female hormone replacement were estrogen compounds.

Source: <https://medical-dictionary.thefreedictionary.com/ERT+or+HRT>

By the 1990s, there was a growing concern about the widespread use of Hormone Replacement Therapy (HRT) as a “remedy” for menopause. In New Zealand, against a backdrop of uncertainty about the safety of long-term usage and the extent of its benefits, this decade saw HRT use double (North & Sharples, 2001). By the mid-1990s up to 40% of women of menopausal age in the United States were receiving HRT, 30% in the United Kingdom and 52% in France (Rubinstein, 2014, p219). During this period, two well-known feminists wrote influential books challenging the high level of HRT use and the treatment of menopause as a medical condition. Germaine Greer’s (1991) *The Change: Women, Ageing and the Menopause* and Sandra Coney’s (1994) *The Menopause Industry: How the Medical Establishment Exploits Women* both raised concerns in relation to HRT. When, in the early 2000s, evidence began to surface that supported their arguments, these concerns proved credible. The most well-known validation was from the Women’s Health Initiative (WHI), whose randomised control trial was stopped when they concluded that “[o]verall health risks exceeded benefits from use of combined estrogen plus progestin for an average 5.2-year follow-up among healthy postmenopausal US women” (Writing Group for WHI Investigators, 2002, p321). Within a year prescriptions for HRT fell and the number of new users reduced by half (Guay et al., 2007).

In the following years, with no other readily available treatment options for those women who continued to have challenging symptoms, the medical profession revisited the WHI study results. A number of things about the study were subsequently criticised, including the study design, the age and symptom profiles of the groups and the reported size of the effects (Rubenstein, 2014). This led to both the North American and British Menopause Societies again recommending HRT as the most effective treatment for menopausal symptoms, albeit with tighter guidelines around its use (The North American Menopause Society, 2012; British Menopause Society, 2013). Women could once again accept medical remedies for their “illness” (i.e. menopausal symptoms), prompting Rubenstein (2014) to predict, “[w]e may be witnessing the re-medicalisation of menopause” (p219). This was borne out in February

2017, when in England NICE (National Institute for Health and Care Excellence) published a quality standard for diagnosing and managing menopause in women (Quality standard [QS143], 2017).

Because of this medicalised approach, the first place women often go to for information in relation to menopause is their general practitioner. While doctors may be competent in addressing the physical traits of menopause, they are often not well equipped to advise women on the emotional and psychological difficulties they are experiencing (Rubinstein, 2014). This may be partly due to a tendency for women to focus on menopause as a process, whereas the medical definition tends to emphasise an event (i.e. the cessation of menstruation) (Lupton, 2012). While a “diagnosis” of menopause occurs twelve months after a woman’s last period, the process to get there can occur over several years and each woman will experience this differently. As noted by Morris and Symonds (2004) “women do not consult the doctor as a blank page; they go already set up with beliefs, attitudes and interpretations of the meaning of the menopause that do not always fit within the medical model” (p316).

Similarly, doctors themselves have their own ways of thinking. As Gracez (2003) found “...medicalised perceptions set boundaries on ways of thinking and feeling” (p32). For women to make informed choices it is important that they receive clear, consistent and impartial information, as the medical profession remains a key influencer on how women make decisions in relation to menopause (George, 2002; Morris & Symonds, 2004). Women who reported receiving conflicting information or were unhappy with their medical experience looked for other ways of addressing symptoms. In Morris and Symonds’ (2004) study, women explored herbal remedies; exercise regimes, and changing some aspects of their work environments (e.g. heat or ventilation) as alternatives, while George (2002) concluded that offering alternatives to HRT such as education, diet, nutrition and vitamin supplements was important.

More recently, in contrast to this approach, the North American Menopause Society, in their 2015 position statement on the non-hormonal management of menopause- associated vasomotor symptoms, advised its members not to recommend as proven, “at this time”, a number of activities that for many women form the basis of their self-care while facing menopause (The North American Menopause Society, 2015, p1). The advice included not endorsing activities such as “avoidance of triggers (for example alcohol, spicy foods, and hot foods or liquids), exercise, yoga, paced respiration, relaxation, over-the-counter supplements and herbal therapies, acupuncture, calibration of neural oscillations {using sound to alter brain activity to reduce symptoms}, and chiropractic interventions” (p13). Such advice would seem to remove almost all non-medical options for addressing menopausal issues. In doing so, it minimises the role of women in making decisions about their bodies based on their understanding of what works for them. Fifteen years on from the Women’s Health Initiative findings, the decision about how to address menopause symptoms for those women who find them distressing, can still be confusing.

Feminist discourses and the embodiment of menopause

During the 1980s, feminists began to challenge the medicalisation of menopause. Despite agreement that some type of reform must occur, it became clear that within the feminist movement differing points of view continued to exist. An article in the Los Angeles Times (Warrick, 1994) outlined the divide that was forming between those feminists who embraced a more “natural” approach to menopause (encouraging self-help approaches such as herbs, vitamins or acupuncture) and those who were taking hormone replacements (often as a last resort when other treatment options were unsuccessful). Warrick (1994) noted that, looking to follow the lead of feminists such as Germaine Greer and Betty Friedan, “women eager to be politically correct are feeling angry and confused” (para 16). She goes on to draw links with the debate around natural childbirth, where the use of pain relief drugs was discouraged, and women who ended up needing them were

seen to have failed in some way. The following quote from the article illustrates how conflicted women were:

A former leader of New York City's National Organization for Women says she pored over stacks of medical literature before reluctantly deciding to begin a regimen of hormone supplements at age 52. 'I vowed I would not feel guilty about taking hormones, and I don't,' she says. 'But if you print my name, I'm through'.

(Anonymous, quoted in Warrick (1994) para 14)

Feminist discourses on menopause offered an alternative approach to the prevailing medical conceptualisation, providing women with a different way of thinking about what menopause meant. This permitted women to reframe their view of what their bodies were doing. As Ussher (2008) identifies, "...describing the existence of a particular embodied change, such as hot flushes, or weight change, does not mean it is a problem; it does not have to be framed as a medical 'symptom'" (p1788). Taking this approach also allows women to join the conversation about their 'bodily signs and symptoms', removing the monopoly biomedical researchers have on doing this (Dillaway, 2011 p206).

Goldstein (2000) argued for an experiential construction of the lived experience of menopause, something she observed among a group of women participating in an internet support group (Alt.support.menopause). Through the creation of a virtual network, the women were able to develop their own discrete and well-defined "medical culture", one where their "subjective experience" was of prime importance (p313). The group also challenged the feminist viewpoint that menopause was "natural and unproblematic" in nature, feeling this "silenced the voices" of those women whose menopausal symptoms did require treatment (Goldstein, 2000 p320).

The value of various medical interventions and the extent to which women should be free to choose the level of care offered to them remained an area of debate among women (Lupton, 2012). At the other end of the spectrum is the

non-intervention view that menopause is a “...natural, physiological and non-pathological event” for which medical intervention is not required (Gracez, 2003, p17). As with other medicalised experiences for women (child birth, menstruation) there often seems to be a perceived ‘right way’ of doing things, depending on which viewpoint you accept as truth, and as a result many women are confused about what a normal healthy menopause looks like (Mackey, 2007; Marnocha et al., 2011). Mackey, (2007) attributes this to a lack of “descriptive parameters” due to the focus of menopause being on the difficulties as “thoroughly problematized” (p48). By framing menopause solely in terms of problematic symptoms (such as hot flushes or night sweats), there is no room to consider other (less problematic) narratives.

The added influence of social expectations on top of how women manage the reality of their embodied changes at menopause can also create extra stress for women. As Ussher (2008) notes “...the way in which (embodied change at menopause) is constructed by individual women will determine the degree to which they are distressing, and whether they are categorised as ‘symptoms’” (p1787). Similarly, Dillaway (2005) argued the importance of acknowledging that the embodied experience of menopause can be both positive and negative depending on the social context within which it is experienced.

In a study looking at women’s experience of being well during perimenopause, Mackey (2007) noted that women’s embodied experience of menopausal symptoms was described by them as causing minimal disruption to their lives. Mackey argued that this group of women had a variety of other changes going on in their lives (e.g. changing jobs, other health concerns, new relationships, blended families), so changes associated with menopause were not the main focus of their attention. However, this group of women had already self-identified as being well during perimenopause and so came to this study with the understanding that menopausal changes and wellness were not necessarily mutually exclusive.

Stephens (2001), in her study on embodiment and menopause, found a moral aspect among women feeling well during menopause. They asserted their lack of problems was due to actions they had taken, such as keeping themselves busy, exercising, and “concentrating on things other than what the body functions are and you just get on with life” (p659). Other women in this study talked about feeling guilt in relation to choosing to address their symptoms, whether through taking HRT or some other type of treatment. Stephens (2001) explained this by saying:

Physical experiences are inevitably interpreted in terms of their social meaning. In the case of menopause, they are interpreted as symptoms or signs of weakness depending upon the context, including the life story context of an individual, and represented or defended in terms of their power to present a self who is a morally virtuous participant in the social realm (p659).

Stephens and Breheny (2008) also identified menopausal women wishing to appear virtuous, arguing this arose from some socially prescribed need. They found two key premises among how the women in their study constructed their lived experience of menopause to justify their choices, “care of the body” and “getting on with it” (p16). In the first one the focus was on taking care of their bodies through exercise, good food, refraining from smoking, drinking moderately and linking this with living a healthy (and therefore virtuous) life. Women who described “getting on with it” talked of an acceptance of what was happening, not “dwelling” on things and the need to carry on regardless, maintaining the moral high ground. Stephens and Breheny (2008) did note that the women who followed the two approaches above were mostly those not overly affected by menopause. In turn, this resulted in women who were struggling with menopausal symptoms, and chose to take medication, being “positioned as failing in virtue” (p17).

Cultural influences

Women across different cultures may experience the same menopausal symptoms, depending on their “cultural and societal filters”, however the lived

experience of each individual woman can vary immensely (Sicurella, 2013, p290). Beyond indigeneity, such things as ageing, socio economic status, relationships and the importance of the reproductive body will influence women's experience of menopause. (Ussher, 2008).

Although there are international studies on the influence of culture on women's experience of menopause, there is little information around Australasian indigenous women. Lawton et al. (2008) specifically notes the lack of documented menopause experience for Māori women. Similarly, Jones et al. (2012) noted, "(f)or the Indigenous women of Australia, the relative contribution of culture, social disadvantage and poor general health compared with non-Indigenous women to the experience of menopause is unknown" (p1). In a comparison of literature looking at the menopause experiences of women from a variety of countries including Egypt, rural North India, Latin America and Asia, a broad range of variation in symptom reporting across these regions was identified (Kelly, 2011). Lifestyle, including food and physical activity, the perception of ageing and the value placed on older women, and the attitude of the women towards menopause, all appeared to contribute to the identified differences.

Another systematic review of the experience of menopause, this time among Aboriginal women across eight distinctive geographical regions, found this group, when compared to non-aboriginal women, experienced menopausal onset at a younger age (Chadha et al., 2016). Despite this, there were considerable differences in how Aboriginal women perceived, experienced, and viewed menopause. An earlier study of menopausal symptoms of Māori and non-Māori women in New Zealand found that although both groups reported symptoms at the same rate, "... Māori were less likely to have ever used HRT ... and only 5% of Māori reported current HRT use compared to 30% of non-Māori" (Lawton et al., 2008, p467). Noting this required further investigation, the authors observed that this difference could be due to inequity in relation to access to medical services and clinical pathways

available to those women, or there may have been a range of views held by them in relation to the experience of menopause and to using medication.

Studies have identified that socioeconomic status may also play a role in women's ability to access resources (including HRT). This is especially true when the cost of accessing treatment and advice is a barrier, while some level of affluence provides greater access to a wider range of options (Kelly, 2011; Gracez, 2003; Lawton, 2008). Women may also have their own traditions around menopause that means they eschew conventional resources and services. This may be relevant following the loss of confidence in hormonal therapies over the past few years.

In western society there are a number of negative connotations associated with ageing women and for many women menopause and ageing are inextricably linked (Rubinstein & Foster, 2012; Hvas, 2006). It has been noted that "...within a culture, a woman's view of her societal importance plays a large part in how she experiences menopause" (Sicurella, 2013, p290). As mentioned earlier, if the prevailing culture does not value women as they age, then women are more likely to experience menopause in a negative way. In a study looking at what social factors impacted on the menopause experience of the so called 'baby boomers'³, Strauss (2011) reports that mid-life women are still largely an invisible group in a culture which promotes youth. In her view, the inclusion of menopause in the literature around ageing would assist in its consideration as a regular life transition.

In contrast Utz (2011), in a study looking at mother and daughters' experiences of menopause, found that the younger women (part of the "baby boomer" cohort currently in their 50s) did not consider themselves old enough

³ A person born in the years following the Second World War (1946-1964), when there was a temporary marked increase in the birth rate.
Source: <http://www.history.com/topics/baby-boomers>

for that stage of life. They were using a range of approaches to obscure the visible signs of the onset of ageing, including cosmetic procedures, taking hormones, dietary restrictions and exercise. Utz (2011) identified that the key issue for those women was one of control and their “desire to personally...self-manage their lives, including their bodies” (p148). Similarly, Stephens (2001) argued that women who perceive that they do not fit the usual older woman physical stereotypes (in relation to how old they looked or what their body shape was) were “pleased and surprised to find they don’t...” (p658). As Ussher (2008) argues:

(t)he embodied changes women experience at midlife ... are not denied, but the ways in which women interpret and respond to these changes is irrevocably connected to the cultural context in which she lives, her own individual life situation and the discursive framework she adopts to conceptualise and position both menopause and aging. (p1793).

The menopausal woman and work

The stigma around menopause sees many women not wanting to admit to being menopausal (Dobson, 2016) and this is often the case in the workplace. Women may feel frustrated at the lack of open discussion around menopause, often talking about barriers such as fear others will view them as attention-seeking, or making excuses (Duffy et al., 2011). They are often unwilling to discuss menopause with younger colleagues, especially if male, fearing “social prejudice” and a perception that others may judge them less competent in their work (Reynolds, 1999, p360). In one study of 896 menopausal women, 11.9% said they had taken leave due to menopause; however of those just 58.5% disclosed to their line managers that their sick leave was due to menopausal symptoms (Griffiths et al., 2013). In an earlier report, Griffiths et al. (2010) noted that some women had not disclosed that menopausal symptoms were a major factor in behaviour or performance issues that resulted in disciplinary action, only disclosing this to their employer when things had progressed to that point.

Often perceived as a “woman’s problem” in the workplace, much like menstrual issues and pregnancy, there is an expectation that women should deal with menopause themselves (Bochantin, 2014 p261). Brantelid et al. (2014) talked about the social stigma around menstruation resulting in women hiding all evidence of menstrual bleeding for fear of “feeling exposed” (p19). Recognising a comparable affect among menopausal women, Kittell et al. (1998) referred to this behaviour as “keeping up appearances” (p618). Similarly, this lack of open conversation about “women’s issues” amongst women, means many women have little idea about what menopause actually involves, what to expect and what to consider as “normal”. Duffy et al. (2011) explored women’s experience of their menopausal symptoms, management and support in the post Women’s Health Initiative trial era. A key phrase from a participant (that was used in the study’s title and was said to reflect the groups’ discussions), was that menopause was “... somewhere between a taboo and a joke” (p502). These women discussed having unsupportive work colleagues, and the majority believed being able to share their experiences with other women would help them better understand their symptoms and obtain support that what they were going through was normal.

With stigma around open discussion of menopause in the workplace, many women are now turning to social media, enabling them to seek support from a large network of people, many of whom they only communicate with through digital means. In a review of an online discussion forum, Bochantin (2014) found that women were using the site www.power-surge.co. for social and emotional support, offering advice to each other and sharing their experiences of working in unsupportive work environments:

These women have shown through their postings that they are often silenced with regard to what can and cannot be said or attended to in the workplace, which has caused a range of contradictions, uncertainty and tension about how to cope.

(Bochantin, 2014, p276).

Society often views participation in paid work as a measure of women's value, especially for older women, and this can have an impact on her self-esteem, health and stress levels (Simon & Reape, 2009; Reynolds, 1999). This makes dealing with menopause while trying to remain competent, professional and engaged in work activities, particularly difficult for many women. Stress may result from either symptoms affecting women's ability to complete work or their work environment making it difficult to manage their symptoms (Nosek et al., 2012). Matsuzaki et al. (2014) linked job-related stress in nurses to the high-pressure environment in which they work, and the amount of shift work that is part of the job; Hamman et al. (2012) associated "work stress and overload"...to worsening of menopausal symptoms (p299), and Abramson (2007) noted the adverse effects on health when work became stressful for mid-life women. Women who were more highly stressed by their work situation were also less likely to talk about being menopausal.

One of the most recognisable issues associated with menopause in the western world is having a 'hot flush' (or flash as they are called in the United States) and for many women, dealing with hot flushes in the workplace is particularly distressing (Griffiths et al., 2010). In a study on managing hot flushes at work, Reynolds (1999) identified that dealing with difficult menopausal symptoms at work may add "additional demands on the coping resources of women" (p360). Reynolds (1999) concluded this was particularly so for those women who found their hot flushes embarrassing and who struggled to reveal their status as a menopausal woman to their colleagues.

The occurrence of a hot flush at work has the potential to reveal a woman's menopausal status to her colleagues before she may have planned to do so (Dillaway, 2011). Recounting their experiences of hot flushes in their work environment, women reported feelings of embarrassment were common, particularly when these happened in front of their colleagues, something Reynolds (1999) referred to as a "stigmatising display" (p358). These feelings increased when the women felt unable to control their immediate situation. An example of this was having a hot flush in a formal meeting situation, trying

to remain composed and reluctant to out themselves as menopausal by “removing a jacket, having a cold drink or wiping perspiration from the face” (Reynolds, 1999, p358).

Women often faced the dilemma as to whether to disclose their menopausal status to their work colleagues, before their bodies did this for them (Reynolds, 1999). One view was that being open about menopausal difficulties was preferable, concluding that for this group it was “...vital for gaining acceptance and support of work colleagues” (p359). In contrast to this, other women were concerned that disclosing their difficulties would “increase their vulnerability to powerfully negative menopause stereotypes” (Reynolds, 1999, p359). How the women viewed these stereotypes and their relation to them, particularly in the workplace, influenced the way they managed visible menopausal signs.

Dillaway (2011) found the visibility of hot flushes, and how best to respond to them, was a key concern for women. She observed that women’s responses to flushing could be characterised in two ways. The women were either ‘accommodating’ or ‘resistant’ to the cultural norms of menopause (p199). Accommodating women were either trying to conceal what was happening to them, particularly at work where they felt colleagues (especially male) would not understand, or the women wanted to minimise the discomfort felt by others as a result of them observing a hot flush occurring. In contrast to this Dillaway (2011) observed other women who actively resisted cultural norms that related to them not talking about personal things such as hot flushes, being apologetic about their occurrence and in the workplace taking responsibility for others’ responses to them. These women accepted that a hot flush was occurring and that it was out of their control – “...flashing in front of others can become more active resistance as women gain experience in responding to others reactions to their flashing bodies...” (Dillaway, 2011 p203).

Some of the women in Dillaway’s (2011) study spoke of using these opportunities (of having a hot flush) to teach others, mostly co-workers of a

similar age, or younger women, about what they could expect through this stage. A key reason the women perceived those particular settings as being 'safe' was that men were not present and Dillaway saw this as showing in that situation "women could be in charge of defining their flashing bodies" (p204). This was also illustrated by Bochantin (2014) who identified women experiencing "solidarity and acceptance" among menopausal colleagues in comparison to experiencing "hostility and rejection" from colleagues who were male (p271).

One of the key pieces of research undertaken on women's experience of working through menopause is a study commissioned by the British Occupational Health Research Foundation (Griffiths et al., 2010). This large study consisted of over 900 survey responses and 61 face-to-face interviews with women working in a range of employment settings including policing, administration, journalism and radio production, and education. The authors identified a range of interest from contributing organisations, with some keen to participate from the start, while others questioned the significance of menopause as subject matter. In contrast to this, participating women were enthusiastic to see the focus on what can be an unmentionable issue, and that women experiencing menopause in the future would have access to the research findings.

The arrival of menopause was something many of the women who participated in Griffiths et al. (2010) study felt unprepared for. The work environment provided a particular challenge in relation to dealing with the issues some of the menopausal symptoms were causing for them. Nearly half of the women indicated some sort of effect on their work performance. Although the women were able to articulate helpful strategies they had established to cope while at work (e.g. changes to heating or ventilation, flexible work hours, disclosing their menopausal status to others or removing themselves from difficult situations) they still identified that they wanted more guidance and support (Griffiths et al., 2010).

Griffiths et al. (2010) highlighted four key areas where employers could provide a better work environment for menopausal women: management awareness, flexibility in working hours, formal and informal sources of support at work, and improved workplace temperature and ventilation. The authors proposed that menopause should be considered as an occupational health issue for some women, and likened it to other “longstanding health-related condition(s)” concluding that “...informed, sympathetic and appropriate support from line management is crucial ...” to providing menopausal women with an empathetic work environment (p54). While such an approach may be helpful for those women who have struggled to manage some of their extreme symptoms at work (e.g. excessive bleeding), it may also foster a medicalised approach for the majority of women who do not require this. Menopause is not an illness; however this study refers to it as a “major health event” (Griffiths et al. 2010, p13). As noted earlier, women may seek information and relief for physiological symptoms from their general practitioner; however there is little research to suggest that women consider themselves ill during menopause. Therefore a focus on general health and wellness may be a more appropriate focus in New Zealand (State Services Commission, 2016).

With so many working women in their menopausal years, and therefore likely to experience some issues at work, it is interesting to note that there has been little attention paid to the impact menopause may have from an economic standpoint (Kopenhagen & Guidozi, 2015). An American study (Kleinman et al., 2013) reviewed the costs associated with working women who had “diagnosed menopause symptoms” (p465). They found that these women had more sick leave, had higher medical and pharmacy costs, and lower levels of productivity compared to other women. Already labelled as “diagnosed”, it could be argued that there is an expectation these women would receive more “treatment” than those women who were not categorised in the same way. Fenton & Panay (2013) argued that as there are also many working women who do not pursue treatment, the identified high costs of those who did could be an indication that this is an issue of some significant scale.

In New Zealand there has been little research on women's experience of menopause in general, or in the workplace specifically. International research undertaken about the effects of menopause on particular occupational groups, including those in the health sector, has been difficult to find. I identified four studies that focused specifically on women working in the health sector, one looking at the experience of teaching staff in an Egyptian government faculty of medicine (Hammam et al., 2012), one that considered the link between menopausal symptoms and job-related stress factors among midlife nurses in Japan (Matsuzaki et al., 2014), a thesis that looked at the experiences of black nurses in South Africa (Chard, 1998) and one that focused on the health, ageing concerns and self-care strategies of older women nurses (Gabrielle et al., 2008).

Despite the lack of local research, the women who participated in the international studies identified a number of concerns that would seem relevant to women working in New Zealand's health sector. These included workplace awareness of health issues and ageing in general (Hammam et al., 2012; Gabrielle et al., 2008); the availability of information about menopause (Chard, 1998); their level of control over their physical environment (mostly in relation to temperature) (Hamman et al., 2012); flexibility of work (Matsuzaki et al., 2014; Gabrielle et al., 2008); the impact of shift work and the high level of stress that is part of working in health (Matsuzaki et al., 2014; Hamman, 2012; Gabrielle et al., 2008).

Mannetje et al. (2009) acknowledged that there was a gap in knowledge relating to women's occupational health and safety in New Zealand, stating that the reason for this lay in "how society has regarded and valued women and women's work" (p110). They proposed that this was in part due to a focus on women's reproductive health in the workplace, with a resulting disregard for other concerns that may also affect women's occupational health. They recommended that there should be more occupational health studies undertaken on women in the workplace, noting:

... occupational health and safety practice and programmes currently in place in New Zealand are largely gender-neutral and assume that prevention programmes based on knowledge acquired from male populations will equally benefit women workers, which has been shown not to be the case (p111).

When I reviewed this report, I found only one mention of menopause where it associated physiological changes during menopause (as well as during menstruation, pregnancy and breast-feeding) as possible factors in susceptibility to occupational cancer (Mannetje et al., 2009, p76).

In contrast, the State Services Commission has produced a summary of information and resources for employers to create policies and programmes that will support wellness for their employees as well as meet their requirements under new health and safety legislation (State Services Commission, 2016). In this document, menopause is identified under a heading “General Health and Wellbeing” (p14) and links are provided for two United Kingdom Public Service Union publications, a guide for safety representatives entitled “(t)he menopause and work” (Unison, 2016a) and a menopause factsheet (Unison, 2016b). Both these documents draw heavily on the study commissioned by the British Occupational Health Research Foundation (Griffiths et al., 2010), outlined above.

Summary

A review of the literature reflects that for women, the lived experience of menopause has changed over time. There has been, and continues to be, a divergence of views as to how women should approach their menopause journey and the literature explores the social, cultural and, to a lesser extent, political influences on women at this time in their lives. I have identified gaps in the literature around the lived experience of menopause for nurses at work, and specifically within a New Zealand context. Jack et al. (2016) concluded that there was a need for more qualitative studies that would result in increased opportunities to hear women’s voices on their lived experience of menopause. This study will endeavour to address these gaps, listening to women’s stories

and attempting to understand what has influenced their construction of their lived experience of menopause. The next chapter will outline the social constructionist methodology and describe the methods used in this qualitative study.

Chapter Three - Methodology

The researcher's task is not to reproduce these accounts as if they offer a privileged representation of social reality but to ask: why and how, do people here come to think, behave and talk like they do.

(Green & Thorogood, 2014 p29)

Introduction

The purpose of this research is to understand the lived experience of menopause for women working in the health sector. When considering the research approach that would be the best fit for this I knew that I wanted to use a qualitative rather than quantitative approach. While noting that there are a variety of definitions for qualitative research, Ormston et al. (2014) concludes that its purpose is affording an "in-depth and interpreted understanding of the social world, by learning about people's social and material circumstances, their experiences, perspectives and histories" (p23). I wanted to give these women the opportunity to share their experience of menopause. Rather than trying to measure their symptoms in some way (for example number of hot flushes, menstrual changes or sick leave), I was more interested in finding out what they thought about their experience, how it had affected them, and how they had fared in a work environment. As Westmarland (2001) noted, when arguing for qualitative methods in relation to research around women, while surveys can determine how common problems are, "interviews are needed to fully understand women's experiences and theorise these experiences with a view towards social change" (p7). It was also important to me to remain mindful of the above quote from Green and Thorogood (2014) as I undertook this process.

Methodology

Green and Thorogood (2014) argued for the importance of identifying and being explicit about one's epistemological position, explaining that this

position has an impact on how the researcher will “generate and analyse the data, and how they view the topic within the broader social and political context” (p. 24). The epistemological approach I have chosen to follow for this study is constructivism, underpinned with some feminist literature.

The constructivist approach assumes that knowledge is actively constructed rather than passively received (Green & Thorogood, 2014; Mills et al., 2006). Constructivism recognises that the process of obtaining information, that is the interaction between the researcher and the participant, will be with a view to generating data rather than collecting it. As noted by Mills et al. (2006), interviews are neither neutral nor context-free, but instead are the result of an active collaboration between the participant and the researcher. While women’s experience of menopause at work is their own individual one, it is the result of many different influences both within their workplace, in their own family and from broader social and cultural influences (Griffiths, MacLennan & Hassard, 2013; Simon & Reape, 2009).

A constructivist approach seeks to explore the significance and insight people attach to their experiences and social interactions, an approach that also acknowledges that an individual’s view of things is “inherently contextualised and therefore specific to time and place” (Loseke, 2011, p368). Underpinning this approach is the belief that there is not one reality or truth, but rather it is their interactions with the world that help determine how people choose to construct their own reality. Foucault (1984), quoted in Lupton (2012 p167) described the role of the researcher as uncovering how “truth” is established, understanding who benefits from that view and then considering the prospect of “a new politics of truth”. Therefore what I “found” from my conversations with women about menopause was a co-construction between interviewer and interviewee. It reflects what we believed was relevant to discuss at that particular time and place. As such I acknowledge that our “truth” is my interpretation from our time together, influenced by my own beliefs, preconceptions and life experience. I explore this further in the section on reflexivity.

A specifically feminist form of research arose from the second wave women's movement that came about during the 1960s and 70s, which saw the development of a new women-centric approach to research including "a new branch of theories, methodologies and methods" (Brooks & Hesse-Biber, 2006, p22). However, as feminist research continued to grow and develop it became clear that there was no one feminist approach. Just as there was a divide between those who differentiated themselves as feminist researchers or not, there was also dissonance "within and between feminisms" (Westmarland, 2001, p1). Acknowledging the many different types of methodology, perspectives and epistemology utilised across feminist research, Brooks & Hesse-Biber (2006) identified that these various approaches intensified an "awareness of sexist, racist, homophobic, and colonialist ideologies and practices" (p4). Regan & Burton (1992) argued more succinctly that "what makes feminist research feminist is less the method used, and more how it is used and what it is used for" (p150). While not specifically taking a feminist approach in this research I have considered feminist literature and am mindful of the privileged position of both myself and my interviewees in terms of the resources available to us throughout menopause.

Reflexivity

Reflexivity requires a researcher to maintain a critical awareness of their own perspective and how it could impact on both the research process and what the outcome of the research is. This is particularly relevant when using a constructivist approach where, as mentioned earlier, interviews result in a "co-construction of meaning" between the interviewer and the interviewee (Mills et al., 2006, p9). Reflexivity requires the researcher to not only understand their role in creating information but also to scrutinise the influence "their biases, beliefs, and personal experiences" have on that interaction (Berger, 2013. p2).

In terms of ontologies, the concept of there being no one truth was of particular interest to me. Hartman (1990) identified that with numerous truths there

were also numerous ways to know. Rather than resulting in confusion, she saw each “discovery” as adding further knowledge so “each way of knowing deepens our understanding and adds another dimension to our view of the world” (Hartman, 1990, p4). However Calás & Smircich (1999) highlighted the importance of reflexivity within this position for me:

...no matter what topic or area or what methods we use – we are all ... putting pieces together, picking and choosing to pay attention and ignore. No matter who ‘we’ might be ... we are... excluding, including, concealing, favouring some people, some topics, some questions, some forms of representation, some values (p664).

It has been my intention throughout the research process to ensure I continued to acknowledge and seek to understand my role in it, particularly in terms of both the immediate setting and the broader social context that this research has occurred in (Green and Thorogood, 2014). This includes recognising that what I have determined as learnings from the interviews is my interpretation or construction of meaning from that interaction.

As stated by Karger (1983) “(t)hose who define the questions to be asked define the parameters of the answers, and it is the parameters of the questions and the ensuing answers that function as the lens by which people view reality” (p203). Although he wrote this within the context of a political and professional struggle occurring at that time around research and the future of social work, this remains a salient point thirty five years later. While Karger’s emphasis is on the powerful role of those defining the questions, interviewees are not passive participants in the process. Green and Thorogood (2014) argued that interviewees undertook their own evaluation and reflections of the interviewer, and this affected how they constructed their responses. I was mindful that as I was not a nurse it may be helpful to explain my work in health workforce development, sharing my knowledge of nursing workforce issues as a starting point. I also chose to share my status as a menopausal woman at an early stage in each of the interviews, partly as a way to help put the women

at ease, hoping to increase the “reciprocity and rapport” between us (Hesse-Biber, 2006. p128).

Berger (2013) discussed the benefits and challenges faced by a researcher who is an “insider”, that is one who shares the experience of the participants, and noted the importance of both reflecting on and questioning the similarities and differences between the two (p4). Being mindful that as the researcher I still held the final say in interpreting and representing the women’s stories, I felt it was important to reflect on what my role in the interviews had been. This is relevant to me as a menopausal woman researching the experience of menopausal women at work. While Berger acknowledged this “insider” position may support a deeper understanding of participants’ experience she also cautioned against the researcher using their experience as “the lens to view and understand participant’s experience” (p12). As a way of avoiding this, reflexivity allows the researcher to consider how they frame, explore, construct and choose to represent the data (Drake, 2010).

When I first started this research process my menopause journey was just beginning. Like many of the women I interviewed I had little idea of what to expect in the coming months and/or years. I approached the interviews with an interest borne not only from my research question but also as someone thirsty for knowledge from a personal perspective. As time has gone by I have gained first-hand lived experience of menopause. In hindsight this has given me a different understanding of just how challenging and difficult some of the situations described by the interviewees were, and also why they may have chosen to highlight some things and not others. I am not sure that I would have undertaken to complete my Masters at the same time as going through menopause, given what I now know about the impact that it can have on such requisite skills as concentration, memory and clarity of thinking. However I believe the fact that I have had an evolving personal perspective on menopause throughout the research process, has added a different dimension. I have endeavoured to remain mindful of how this may have been both “a hindrance

and a resource”, as I have reflected on my part in the research process (Brooks & Hesse-Biber, 2006. p15).

Methods

A purposive sampling method identified participants from within the workforce of the Canterbury health system. This method required participants to meet a set of criteria, defined at the beginning of the data collection, and excluded anyone who did not meet the stated requirements (Denzin & Lincoln, 2011). For this study selection was dependent on women being able to provide specific information on their experiences of menopause within a health workplace (Christchurch Hospital), therefore contributing their unique perspective (Liamputtong, 2009). Purposive sampling helped ensure that the selected women would produce sufficient “appropriate and useful data” to answer the research question (Green & Thorogood, 2014, p121). To find possible participants, I employed a combination of firstly placing flyers around Christchurch Hospital, and secondly using existing networks. This second activity is known as ‘snowball sampling’, where one contact is used to recruit another who in turn may establish further contacts who are relevant to the research topic, so that the number of participants “... increases rapidly or ‘snowballs’.” (Longhurst, 2009, p580). By using this sampling method (the snowball technique plus self-selection) I recognised that participants may have been more likely to be having issues at work and therefore be willing to discuss these with me. Indeed, many of the women described discussions amongst colleagues about this research prior to my interviews with them.

An initial search for data in relation to the menopause experience of Māori women resulted in only one paper which noted that their study provided “... the first data on the menopause symptom profile of Māori women, as compared to non-Māori women in New Zealand” (Lawton et al., 2008, p468). It was clear that there is a gap in information about how Māori women experience menopause within the wider context of Māori women’s health, as well as in a work environment. Initially I wanted to try and recruit as many

Māori nurses as possible into the study, but realised this was unlikely to yield more than 2-3 participants. Of the 3472 nurses in the Canterbury District Health Board in 2016, just 71 of them identified as Māori, which is just 2% of the nursing workforce (South Island Workforce Development Hub, 2016). Prior to commencing this study, I undertook Māori consultation with the Māori Research Advisor at the University of Otago Christchurch Campus. I also made contact with a colleague who works closely within Māori networks and arranged to share the information in relation to the proposed research in the hope of directly targeting Māori nurses. Although this did not result in any participants who identified as Māori, in hindsight the time restraints on recruiting participants was not sufficient for myself as a non-Māori woman to undertake recruitment in a culturally appropriate way.

Participants

Women who responded to the flyers received further information about the research (Appendix A), asking them to respond if they wanted to participate. Sixteen nurses received information, with eleven of these eventually interviewed. Qualitative research makes no claims to generalisability, although the themes from this study may resonate with midlife women similar to those who participated. The small sample size was necessary, due to the time constraints in undertaking a Master's thesis. However, as expected, this number was sufficient to achieve data saturation. Saturation occurs when no new themes appear. This usually occurs between six and twelve interviews, depending on sample homogeneity (Guest et al., 2006). The participants identified themselves as being perimenopausal or menopausal, and ranged in age from 47 to 55 years old. They held a variety of positions within Christchurch Hospital including enrolled nurse, registered nurse, charge nurse, clinical nurse specialist and a nursing director. The participants came from seven different clinical areas, with one area providing four interviewees. I thought those from the same area may have shown some reticence in relation to what they discussed knowing their colleagues were also participating;

however, this did not occur. Although I found my participants almost immediately, arranging the interviews took somewhat longer.

Data generation

The participants chose the time and a place for the face-to-face interviews to occur. Although several of the women preferred to meet away from their place of work, interviews mostly took place at a café at Christchurch hospital. The hospital café was a noisy backdrop to the interviews although this background noise meant others were less likely to overhear our conversation. Interviews lasted between 40 minutes and one hour, and the discussion was audio taped using a digital recorder. Prior to the interview, participants received an overview of the study and a written consent form (Appendix B) that outlined data generation, the general line of questioning and the right to withdraw from the project if they changed their mind.

I used the 2013 census ethnicity question to record participants' ethnicity (Statistics New Zealand, 2013). All participants identified as New Zealand European. This reflects the majority of the Canterbury District Health Board nursing workforce, 74% of whom identified with this ethnicity in 2016 (DHB Shared Services, 2016). During data analysis I realised it would have been useful to ask about shift work and family situation at the beginning of the research process. It became clear when reading the transcripts that these were important areas which contributed to the women's experience, as this information often occurred incidentally in the interviews. In hindsight I would have liked to have gone into these areas in greater depth. Throughout the data analysis and final write-up process I assigned each participant a pseudonym to protect their privacy. Ethics approval for the study was sought from the University of Otago Human Ethics Committee (Departmental Approval) with final approval given in July 2016.

As a way to enable the women in this study to provide a subjective voice around their menopause experiences, I chose to undertake in-depth, semi-

structured interviews (Liamputtong, 2009). Using this technique, together with an informal café setting, the interviews could evolve in an informal conversational way, over coffee. Although I determined the questions asked, the women I interviewed decided what types of information they would share and the level of importance attached to the subjects raised (Green & Thorogood, 2014). It was important to ensure sufficiently structured interviews so as to focus on specific aspects of the research question, while still providing an opportunity for the women to offer new meanings during the discussion (Galletta & Cross, 2013). To facilitate this the interview guide (Appendix C) was flexible, allowing the opportunity to explore any new areas of interest that arose during the discussion. I found that once the interviews were underway the women talked about many of the key areas without specific questioning. Once the audio recording stopped at the end of the interview several women continued to ask questions or chat, some sharing information they did not want recorded. Where this was relevant to the interview I made notes immediately afterwards and included these observations with my transcriptions. Each participant received a \$30 voucher as a gesture of appreciation for their participation.

Data analysis

I transcribed the recorded interviews verbatim as soon as possible after the interview took place while the conversations were still fresh in my mind. Undertaking this process myself was an important part of becoming familiar with the data, recognising that this was also the beginning of my interpretation and construction of meaning of my interviews with the women (Green & Thorogood, 2014). Galletta and Cross (2013) recommended an immersion in the data, especially “...the stories, images, metaphors, pauses, and emotions narrated by the participants, as well as the interactions between the researcher and the participant” (p122). I tried to be mindful of this immediately after the completion of each interview, taking notes in relation to anything that was particularly memorable or would help me remember specifics of the particular women I had interviewed. These notes were at times

helpful when thinking about how the women shared particular stories or comments. Once transcribing was complete, the process of undertaking a thematic analysis of the transcriptions commenced, enabling the identification of patterns within the data and connections between those patterns (Braun & Clarke, 2006, Liamputtong, 2013).

I began by immersing myself in the data, reading and re-reading each transcript through a number of times, taking notes as I went. I carried out initial coding during this process, highlighting similar themes. Data often appeared to relate to more than one code or theme, so themes and codes underwent continual review and refinement (Dworkin, 2012). To assist in this review process I underlined passages of text in various colours and began collating quotes under identified themes as I tried to explore the underlying themes that emerged, eventually refining these groupings into three key areas. These were “a recalcitrant body” (perception versus reality), “constructing a menopausal identity” (how do I want to do this) and “great expectations” (being everything to everyone). As suggested by Braun & Clarke (2006) I found drawing a “thematic map” a good visual way to represent those key themes (p21). It continued to be a useful tool as I developed my findings chapters, referring to it often throughout the writing process.

Summary

This chapter outlines the methodology used to explore how the women in this research came to think about, talk about and experience menopause as they did. Underpinned by a social constructivist approach, I have tried to align this research with a feminist perspective, while also reflecting on my role as an “insider” in co-constructing the data (Berger, 2013).

Over the following three chapters I discuss my findings which consider what the eleven nurses shared with me, not only in relation to their workplace, but also within their wider social context. A range of social theories have been utilised to consider the experience of menopause for these women within the

identified themes. These included theoretical concepts relating to embodiment, stigma, impression management (Goffman, 1959, 1990) and emotional labour (Hochschild, 1983). I then examine the influences outside of work with reference to Hochschild and Machung's (2003) "second shift" (referring to the unpaid work women often undertake in the home), Miller's (1981) "sandwich generation" (where women, usually, often have children still at home while ageing parents are increasingly requiring assistance) and Burn & Szoek's (2016) "boomerang children" (the return of adult children to the family home). I begin by considering the challenges of managing a "recalcitrant" body within a place of work.

Chapter Four - A Recalcitrant Body

The unpredictable menopausal body – which might emit heat, smells, or even blood, is positioned as cause of offence; corporeality exposed in a manner which is out of the control of the woman. Given this, it is not surprising that the changing menopausal body is shrouded with shame, and many women are silent about their experiences.

(Ussher, 2008, p1793)

Introduction

Women of my mother's generation (mostly in their 70s or 80s now) often referred to menopause as "the change", if they spoke of it at all. Mid-life is still a time of great change for women and for the working woman it can be a particularly difficult time. As the above quote from Ussher (2008) shows, it is the nature of menopausal bodies, leaking and out of control, with the potential to mortify women in front of others that contributes to this difficulty. A menopausal woman is positioned "physically, hormonally and emotionally in her changing body" (Nosek et al., 2012, p2). While everything the women in this study experienced was normal for someone during menopause, within the wider context (and particularly in the workplace) visible displays may have felt "abnormal, disruptive and negative" (Dillaway, 2011, p204), thereby contributing to the silence around the reality of menopause.

Ussher (2008) suggested a broader consideration of women's midlife embodiment that goes beyond physical and psychological "symptoms". She argued the conceptualisation of both menopause and ageing occurs within a broad framework which includes both women's individual life experiences and the broader cultural context within which she lives. Ussher's "material discursive approach" is a way of viewing the interplay between the reality of women's embodied experiences and the cultural and social contexts they inhabit (p1781). Stephens (2001) highlighted the complex relationship between embodiment and the body in social contexts as she considered

“having and being a body in a social world” in relation to the experiences of menopause (p654). Emphasising the uncertainty that is caused by selves who “both have a body and are a body”, the former being the “object body”, the latter the “subject body”, she considered these in relation to a scale of “social functions”, ranging at one end from “the individual body” to “the body in society” at the other (p653). This chapter will explore the participant’s experience of both having and being a menopausal body within the workplace.

Uncooperative bodies

After reviewing interview transcripts the term “recalcitrant” came into focus as a key component of how the bodily experience of menopause affected these women. According to the Oxford English Dictionary (2017) “recalcitrant” is defined as being “uncooperative, refractory; objecting to constraint or restriction”. Prior to identifying “recalcitrant”, I considered the term “misbehaving” as a descriptor; however it never seemed quite right. If something is “misbehaving” it is deemed as behaving badly; (or showing) improper conduct, misbehaviour (“Misbehaving”, 2017). While not that different in meaning to recalcitrant, it is the connotation of women doing something wrong that did not sit well for me.

Bodies are not fundamentally naughty; rather the women who were interviewed for this research spoke of coping, in a range of situations, with bodies that were being uncooperative and disruptive. They spoke of unsettled emotions, mood swings, unexpected tears and increased levels of anxiety. Physically they were managing hot flushes, tiredness, heavy bleeding and disrupted sleep. Kittell, et al. (1998) argued that where women place an idealistic importance on being able to monitor and control what they are experiencing, they may come to believe that not only is this possible, it should be achievable. Failure to control obvious physiological signs is therefore likely to increase the stress felt by women who are struggling to achieve this. Lack of control over what, when and how their bodies reacted to being menopausal proved both a source of frustration and often embarrassment for the women in

this study. The importance of being able to present an “exterior of control and normality” was evident (Morris & Symonds, 2004 p316). This expressed itself in how they described the changes they were experiencing, with some, like Karen, recognising that this had an impact on their work.

Yeah, so you're at a peak where you have to be able to respond at any time so you have to be at an alertness...It's sort of a protective thing so that you have to look after yourself so that you can cope and that's what I said to my GP. If I was at home I could open a window, I could take off an item of clothing and I can get a flannel, and if I don't sleep, well then it doesn't matter. But when people's lives are at risk and you need to function at a high level then you have to protect yourself, be as sharp as you can. (Karen)

Eve, in support of this, summarised things more succinctly.

It doesn't stop you from working but you're not really on your 'A' game. (Eve)

In the workplace particularly, menopause is not always openly talked about and this is often due to it being seen as a “woman’s problem”, similar to menstruation and pregnancy, which women are expected to deal with themselves (Bochantin, 2014 p261). For example, pregnancy is a very visible journey for women at work (their changing body can only be concealed for so long), and the stigma associated with menstruation results in a fear of “feeling exposed” if women fail to hide all evidence of their bleeding (Brantelid et al., 2014, p19). Describing the body as “an active vehicle for lived experience” Shilling (2012) observed that each individual will live that experience through their own lens (p241). Accordingly, how women construct their menopausal experience affects the distress they feel and how they react to those embodied changes. Morris and Symonds (2004) argue that in the workplace this distress occurs due to the “theoretically non-gendered {work space} but which in

reality is based on an unproblematic male body” and therefore not set up to accommodate menopausal women (p314). Women in the workplace can be seen as disrupting this androcentric space and are expected to “manage their bodies” so as to avoid drawing attention to them (Morris & Symonds, 2004 p315).

Likewise Shildrick (1997) spoke of the female body having a “putative leakiness, the outflow of the body which breaches the boundaries of the proper” (p16-17). While Shildrick noted that males could also be seen as leaky in their own way, she concluded that “...what is understood as a matter of avoidable excess for the male is with the female intrinsic” (p220). Her conclusion that the intense scrutiny of woman’s bodies “speaks to a deep cultural unease with the embodiment of women” (p170) is reflected in how the women spoke of trying to conceal the evidence of their leakiness within the workplace, whether that was blood, sweat or often tears.

Yeah well you feel dirty and revolting and sweaty. You can't wait to get home and have a shower, get your shoes and socks off.
(Hannah)

Shame is inextricably linked to the menopausal body, and many women are reticent about openly speaking of their experiences (Ussher, 2008, p1793). The resultant lack of discourse means the reality of menopause is an unknown for many women, often leaving them unsure of what to expect and what is considered normal. For instance many women have a perception that menopause will occur in an orderly way over a couple of years. To learn that women often continued to have hot flushes for a number years after their periods stopped, or that periods could continue into their late 50s, was a cause of concern. As with other menopausal experiences and symptoms, understanding that other women were also having issues was reassuring, especially for women who were struggling and confused with how their bodies were changing.

I grew up believing that 50 was the ... so everything was going to be done and dusted by the time I was 50. So you know to carry on after 50 is very deflating... It's just a normal process and I'm getting more accepting that being the age that I am is normal. I was beginning to think that I'm abnormal. You know everybody else is finished and I'm carrying on. (Marie)

It was only when I started getting hot flushes that I started looking at things, up until then my periods had started changing but it was really only that that triggered it you know. I'd get a hot flush and then it would go away ... But I'm a little bit scared you know, you think gosh what if I'm going nuts? ... Looking back it was probably going for a while but I thought, no I'm too young, it must be something else. And then the hot flushes started kicking in... my period stops, this is not normal... because that's the thing that worries me the most. I don't think I'm losing the plot but I just think why did that upset me, why am I not handling this? And it's good to hear that, that's normal. (Hannah).

Women are often confused when their actual experience differs from what they thought would happen (George, 2002). For those with very definite expectations that had not eventuated, such as Marie, the disappointment at not following an exact timeline or possibly not being able to remain in control was a challenging aspect of their menopause experience.

But I'm learning that there are women at the other end of 50 ... and what I am, what I really want, what I'm aiming for and what I really want is to keep all my bits. I've been told, I've complained about what's going on for me and I've been told oh just go get it out... It's major surgery, it is a major thing. I think and I imagine though that if I did have to have surgery there would be a grieving process. ... It's a choice that's been taken away. (Marie)

Hyde et al. (2010) highlighted disparate medical and feminist discourses, the former focussing on hormones, age and menstruation, the latter seeing menopause as a natural life process. The influence of medical discourses in determining women's embodied experience was, they argued, often at odds with how women described their lived experience of it. Noting that the feminist approach could be equally criticised for the same shortcomings, Goldstein (2000) observed that restrictive characterisations of menopause minimised both its "somatic nature" and the reality of the women's "physical, psychological, and social situation" (p310). These conflicting viewpoints contribute to the lack of clarity around what a normal healthy menopause looks like. Mackey (2007) argued that research has "problematised" menopause and that it is more useful to focus on the embodied experience rather than perceived problems (p48). While Morris & Symonds (2004) concluded that women often present to medical professionals with mindsets, thoughts and interpretations of menopause which the medical model does not account for, Marnocha et al. (2011) argued that instead of receiving information and a "normalisation of their experience" they often received prescriptions instead (p234). Prescriptions for hormone replacement therapy and antidepressants were provided for several of the women in this study; however many of them preferred to try a range of remedies to address what they were experiencing, including herbal tablets, exercise, diet and acupuncture. Still, the choices they made were not without conflict for them and several women spoke of weighing up their options before making any decisions.

But I have researched some different stuff and tried some herbal type remedies I don't want to do HRT and I think you have to wait a year anyway but I just vowed and declared I wouldn't take that stuff and I haven't. And some of the supplements are quite good, it is better now than it was. (Yvonne)

Feeling anxious is a common occurrence among perimenopausal women, most often viewed as related to fluctuating hormone levels, although there is

conflicting research on the link between menopause and anxiety in general (Bryant et al., 2012). In contrast to this Bauld & Brown (2009) found that high emotional intelligence was linked to positive attitudes to menopause, resulting in lower levels of stress and anxiety. Despite this uncertainty several of the women in this group spoke of feeling anxious or depressed, with some having been prescribed medication for this. One woman also spoke of having gone through a suicidal phase, and although she was reluctant to attribute this directly to menopause, it occurred during that time. As Karen outlines below, regardless of the cause, when anxiety and menopause occur together it can be a difficult time.

It's um a very stressful (work) place and things that increase my anxiety, I have a little bit of anxiety, but you know I'd say I managed that myself, quite well but that on top of everything, the environment, and having a little bit of anxiety ... you know the workplace and the menopause was a bit much... Whether it's related or whether some of us just are anxious people, not that you can even have control of that. You do things differently, I've learnt how to manage that over the years to make things better with that but some of us are just anxious, it accelerates that. As we have certain things in our lives, difficult things to manage, changes, our anxiety is heightened by things like that. (Karen)

The overall feeling of not being in control of how their body was reacting during menopause, together with the heightened sense of anxiety experienced by some of the women, was set against a backdrop of post-earthquake Christchurch⁴. The majority of the interviews were completed shortly after the ensuing 7.8 magnitude Kaikoura earthquake in November 2016 . For those of

⁴ In September 2010 Canterbury experienced a magnitude 7.1 earthquake, followed in February 2011 by a 6.3 magnitude quake in Christchurch that resulted in the deaths of 185 people. There were also numerous aftershocks between these two events and in the years that followed.

us who were in Christchurch during the February 2011 earthquake and the many subsequent aftershocks, that time is never far from our consciousness. The Kaikoura earthquake seemed to heighten residual levels of anxiety from that time both within the wider community and for many of the women interviewed (Broughton, 2016). During the interviews a number of the nurses mentioned their experiences working in Christchurch hospital at the time of the 2011 earthquakes, reflecting on the heightened anxiety they were now experiencing during menopause and in some cases linking the two experiences.

I'm probably a little bit more anxious than I used to be. I was probably more of a confident person. ... I mean the anxiety thing is I think a little bit earthquake involved because I was here that day and the months ensuing after that you know, patients screaming every time another shake happened because they were so scared and just awful things and you think you're fine but it's only probably been this year that I've realised (I'm not). (Yvonne)

Two of the women were still in the process of negotiating final settlements for their earthquake damaged homes while another described a new-found fear of heights that she attributed directly to her experience in the hospital building during the Christchurch earthquakes. Research undertaken by Johal and Mounsey (2016) looked at the impact of the Canterbury earthquake sequence (which commenced in September 2010 with the Greendale fault 7.1 magnitude earthquake) on both general practitioners and nurses in the Christchurch area. They found that there had been an impact on both the professional and personal lives of the nurses they interviewed. Work environment was identified as a large source of stress post-earthquake, as the nurses continued to work in damaged buildings that were being repaired around them.

Changing work environments due to ongoing repairs were still an issue for the nurses who participated in this research (three years later) as they continue to experience location shifts while awaiting the completion of the new Acute

Services Building at Christchurch Hospital, scheduled for completion in 2019. One nurse was in her fourth location post-earthquake, with others commenting on various shifts in location as well as their less than ideal working conditions post-earthquake. While there was recognition that these issues were beyond the control of their employer (the Canterbury District Health Board) they identified that this had contributed to higher levels of stress for them on top of the changes they were already experiencing as a result of being menopausal.

Changing times

Although change is perhaps the only constant across women's experience of menopause, it is the variety of this change, especially in relation to their bodies, that caught many of the women unawares. Despite their nursing training providing them with an understanding of how the human body functions, many of the women were initially unable to recognise that what they were experiencing could be attributed to menopause. This incongruence was also described by Marnocha et al. (2011), whose qualitative study asked women to both describe and draw their menopausal journey. They described menopause as a "developmental transition" with accompanying stages, the first of which was the women's growing awareness that a transition had begun (p232). Once the participants in this study began to understand that their bodies were changing due to this life stage (that is menopause) they started to link some of those things together. This included how they were sleeping, coping with shiftwork, and the impact on their relationships with their partners.

Lack of sleep through disturbed sleep patterns often, but not always, linked to hot flushes or night sweats, was common among the women. Disrupted sleep can impact on both a person's wellbeing and their ability to function (Uehli et al., 2014; Fidele, 2015). New guidelines released in 2015 by the American National Sleep Foundation recommended sleep times for various age groups (Hirshkowitz et al., 2015). The sleep time range for adults aged 26-64 years

recommended a minimum of 6 hours sleep (and a maximum of 10) with the recommended range being between 7 and 9 hours. Many of the women in this study reported sleeping less than the recommended minimum of 6 hours, and spoke of how that shortage of sleep affected their ability to cope with work in general and shift work specifically. Describing the impact for her of the change to her sleep patterns, Teresa, like several other women, highlights memory issues, although not all women linked them directly to their lack of sleep.

I have some terribly disrupted nights of sleep and on those days I think I am definitely functioning below par, I actually know that I have some points where I ... there are parts of my brain that are totally, there's just a total switch off. So like today I was trying to think of a name of a suburb, can you believe it, and it's just completely gone. I couldn't think what that suburb was. It's like there's an absolute gap and um sometimes I find that quite frightening ... I think it's like when it's related to a clinical issue, which I, I don't work in an acute area, so I'm lucky. But do you know what I mean? It might be like a normal value of something, for example, and I'm thinking oh my God, I should know this and it just goes (mimes hand going over her head)... Yeah, it comes back, but it's just like I think well how could you have not known that? And it just like it's completely gone. (Teresa)

Griffiths et al., (2013) surveyed 896 women in the United Kingdom and they similarly reported menopausal women feeling down, having decreased confidence, experiencing difficulty concentrating and feeling fatigued. Several of the nurses I interviewed had experienced “near misses” at work, while others talked of feeling less safe in their practice. One spoke, after the conclusion of the official (recorded) part of the interview, of a medication error incident she attributed to a lack of sleep. She was about to give someone the wrong dose of drugs, which could have had major consequences, when a colleague picked up the error at the last minute. Speaking of feeling unsafe at times at work, others noted that they were more nervous about making a

mistake now than they would have been when they were younger. With minimal sleep, well below the recommended six hours outlined earlier, it was unsurprising the nurses such as Yvonne struggled.

When I was younger and did night shifts I'd sleep all day, it didn't bother me. Now I'm lucky if I get 2-3 hours. I'm always up to the loo and I force myself to go back to bed and try and sleep. And sometimes I sleep and sometimes I don't. It's like it makes you feel quite unsafe to know that you haven't had sleep you should've had and I do tend to worry. (Yvonne)

Nurses who were in a managerial position had observed the effects of disrupted sleep on women they were supervising. In some instances the recognition that changed sleep patterns were affecting the work of nurses in their team, only occurred when they reached a menopausal age themselves and understood what could be going on for their staff.

... If they're in their early 50s I do think if they've had to change their sleeping patterns, and for some people who won't let on, maybe they're in a really bad way. There's a couple of women I've sent to the health (centre) ... maybe there's something they can do to help them to sleep better. (Eve)

Ongoing tiredness, combined with a reduced ability to manage this as they age, was highlighted in a study of New Zealand nurses aged over 50 who were surveyed on their experiences of working shifts (Clendon & Walker, 2013). Respondents either indicated shift work suited them (often despite acknowledging some negative impacts) or they indicated a preference to move to part-time or casual work rather than continue to work shifts. Many recognised that while shift work was having an effect on both their own lives as well as their families, the regime of shift work was an integral part of their working life as a nurse.

Despite shift work comprising a fundamental part of nursing, many of the participants in this study found that as they reached menopause they became disillusioned with it. Although just three of the women interviewed did not work shifts, the others were ambivalent, with several looking to move to other areas of work because of them. Like the nurses in Clendon & Walker's (2013) study, the women working shifts mentioned challenges around their ability to cope with, and recover from, the changes to sleep cycles that are required to function well when undertaking rostered work. Completion of a roster often resulted in subsequent days off spent recovering before the next roster began. It was clear that the added pressure of menopause and its resultant sleep disruption, mood swings and tiredness added a further layer of complexity.

Because your sleep is disrupted anyway I think, more than you realise. Like even though I don't get hot sweats now I quite often wake up 3 or 4 times a night ... That's a change for me. I used to put my head down and wake up in the morning but I don't anymore and that's been a change in the last couple of years. So um my sleep's disrupted anyway and then doing night duty, it almost kills me. And I get moody, I get irrational and I'm on the edge of tears. It's like being in permanent PMS and we do nights every 3 weeks. More than a third of our shifts are 10 hour duties. And that's, that is one of the main things that may cause me to leave my job. Because in the week leading up to it I get anxious, I get stressed. During it I just don't talk to anybody, so I sleep or I'm at work. And it takes me every single one of my days afterwards to recover before I go back. And I'm not alone, you know we talk about it. I talk about it with some of my colleagues who are a similar age to me and they're the same. It's like this is just cruel, but the policy of the department is if you want to work here you've gotta suck it up and do it. (Beth)

Although some of the nurses directly attributed their hesitancy around shift work to coping with menopause as well, several of them linked it more directly

to ageing and their ability to cope physically with changing rosters and shifts. This is similar to the findings of Clendon & Walker, (2013) who also reported nurses identifying reduced ability to cope due to the effects of fatigue.

As well as the difficulties of shift work and lack of sleep, many of the women were also struggling with a change in both their physical and emotional relationship with their partners, often speaking of having low libido (often accompanied by vaginal dryness) that they attributed to menopause. Mentioning this towards the end of the interview, several spoke after the audio recording was completed and the more formal part of the interview was finished. The women were hesitant in raising this, yet clearly felt it was important to do so. Most of the women had discussed this with their partners, and while some spoke of feeling a type of grief for the loss of this part of their relationship, others seemed resigned to this being an inevitable part of menopause.

I think one of the big things, this is really personal but it affected me big time is that (husband) and I had a really good sex life and I basically feel like that has gone away and that was really sad. I lamented that, I grieved for that and I also found it initially hard to stomach that it's really different now. But we talk about it. He realises it's different and he doesn't try to put pressure on me ... and yeah, so that's hard. I think that's the hardest bit of it is coming to terms with what was really enjoyable and a lot of fun is sometimes more of a chore. (Eve)

Seeking solutions to sexual difficulties or changes in menopause often leads to a trip to a general practitioner, resulting in the issue framed from a medical perspective as something requiring treatment. Rather than considering a medical solution, although they were aware that these existed, the women who mentioned this as an issue seemed to manage by being open with their partners and finding a way forward together. In their study of sex, menopause and social context, Hinchliff et al. (2010) found that how menopausal women

expressed their sexuality was influenced by both biological and psychosocial aspects, noting the variety of women's experiences. It is this diversity of how menopausal women experience their sexuality that women in this study were not always aware of.

...um and then of late a couple of us have been talking about having low libido, cos that exists and um I'm so pleased I'm not the only one. (Isla)

Despite the participants linking changes to the physical side of their relationships with menopause, exactly what role menopausal changes play in the sex life of mid-life women is unclear. Changes in sexual relationships at midlife may result in women experiencing a loss of physical pleasure, as well as facing uncertainty around the physical expectations within a relationship, often leaving the women anxious about how this would affect their relationship (Stephens, 2001). Hinchliff et al. (2010) noted that most research around menopause and sex occurred within a medical framework (p725), while Winterich (2003) found that women highlighted social influences such as "status and quality of relationship, health and sexual history" (p640) rather than hormonal changes. Koch et al. (2005) found body image also had an impact on sexuality, however they linked this to ageing rather than menopause specifically. None of the women in this study mentioned body image directly, although indirectly spoke of changing body shapes.

Hot and bothered, it's no laughing matter

Many of the bodily expressions of menopause occur in a visible way, meaning they are often experienced in front of other people. When this occurs in the workplace it can be particularly difficult, as many of the women in this study described. Mostly this related to hot flushes; however others were managing heavy bleeding, mood swings or unexpected tears. Feelings of embarrassment and unease were common with many of the women expressing a sense of loss at no longer being able to rely on their bodies to behave as they should, that is,

as they did when they were younger. One of the more challenging of those conspicuous signs involved experiencing a hot flush. Various descriptions included “your blood is boiling” (Hannah), “you feel like your chest is on fire” (Beth) and “I’m going to be like a volcano” (Karen), there was no hiding from their occurrence and the women were very aware of this.

Hot flushes were an obvious source of distress for the women, although this was tempered by the situation and company they occurred in. Often when the visible signs of a hot flush were extremely noticeable they provoked comment from others. Whether this was helpful to the women depended on where they were and who was there at the time. Dillaway (2011) identified a range of ways women respond to “flashing”⁵ in front of others. She found that women tend to “locate themselves and their bodies in a given moment and setting” before deciding how they would react (p205). For those nurses with colleagues of a similar age and stage of life this seemed to provide a supportive environment where they could openly acknowledge and discuss what was happening. Standing in front of a fan to cool down was more likely to result in supportive comments or knowing looks. Where colleagues were younger, as in Teresa’s situation, there was a perception that those colleagues would not understand.

... I wouldn't go down to the ward, because I liaise between the ward and the community, I wouldn't sit amongst a group of 25 years, I'd never talk about my menopausal symptoms with them. Because I think you're already feeling slightly under the hammer about your age anyway, you know inside you still feel like a young person but then you realise they're actually looking at you and thinking oh you're the age of their mother and I don't feel that way. So I guess you then don't want to be talking about that stuff as well so they don't really want to know. (Teresa)

⁵ In North America “hot flushes” are known as “hot flashes”

Women often have to work hard to ensure that what is happening with their bodies does not have a negative impact on their work performance (Griffiths et al., 2013). Those working in roles where interactions with others was key (teachers, receptionists and business women), also worried about how their bodies would affect their ability to do their work (Stephens, 2001). When performance is affected, the women I interviewed observed that empathy was not always evident among other (often younger) work colleagues. Experiencing an incident at work where she lost her temper with a doctor, yelled at her, slammed down the phone, threw a chair at a desk and then burst out crying, Carrie was open about why this occurred. Despite a complaint made about her, Carrie apologised and explained her behaviour to both the doctor and her work colleagues, clearly linking it with the hormonal issues which were affecting her at that time. She reported they were all supportive and understanding of her which helped alleviate her distress at the incident. When Carrie experienced another situation where she behaved inappropriately, her younger work colleague had little empathy, challenging her for her unprofessional behaviour. In that situation Carrie made a decision not to discuss it further with them, clearly feeling they would not understand.

There was one time when I was having a, my switch was flipped and um, there was just a lot of stress and the way I deal with it is I clamp right down. And I had this junior person tell me that it was completely unprofessional and ... I had the greater wisdom of years to keep my mouth shut... I just smiled knowing that yes, I probably could have handled it better but sometimes you just can't help yourself ... And that's not an excuse for behaviour, because people don't know me to be like that. (Carrie)

Keeping menopause hidden, in line with a tacit social convention that the experience of menopause should remain private, involved trying to discreetly conceal any evidence of it (Sergeant & Rizq, 2017). Attending to bodily expressions such as heavy bleeding or hot flushes was easier for some of the women because of the position they held at work. Being in a "9-5" managerial

type role meant more autonomy around being able to remove themselves from situations, to either take some time to cool down or go to the toilet to address heavy bleeding. Beth was in a role where she was able to attend to herself in a timely way when she experienced her main menopausal symptoms. However she was one of several participants who acknowledged that this was not necessarily the situation for their fellow workmates.

... I would not have been able to manage it doing what I do now. It's interesting, I do see some of my colleagues at work and you see them rush to the bathroom and you think shit, I bet I know what you're going through and it must be so hard to manage. So I've been really lucky that I haven't had to manage that since I started back on the floor, thank God. (Beth)

For others, like Hannah, there was little choice.

Well I just start sweating and I'll sweep my hair back and I'll just carry on and then once I'm finished I'll go out and get myself, you know, sorted. There's not much you can do, you can't stop... You don't really have a choice, it's too busy in our ward. You can't go out and get some fresh air or anything like that. (Hannah)

This difference in ability to immediately address their bodies' needs was noted by several of the women who were in ward situations as opposed to a more flexible work role. Although they were of similar ages, that is around menopausal age, there was a feeling that their supervisors did not really understand how hard it was for them because they were not exposed to the same difficulties. Hannah would not discuss the menopausal issues she was having with her supervisor because she felt that she would just be told to "harden up". Other women spoke of how supportive their supervisors were, so this clearly was not the case for all; however the feeling of a disparity between opportunities for coping (and thereby concealing) was acknowledged.

Nurses working in more patient-focussed areas described hot flushes as an acutely embarrassing experience with several mentioning situations in the workplace where, when undertaking certain tasks, they were unable to attend to themselves. Two such examples were of having to wear protective clothing while showering a patient in a hot un-airconditioned and unventilated shower room; and the other was where wearing a gown was required when undertaking patient dressings in a sterile environment. In a discussion post-interview one of the women spoke of her distress and self-consciousness at being so wet under her protective clothing that when she was finally able to take the top layer off, she could physically wring out her own clothing underneath. These outward displays of a clearly leaking body resulted in feelings of shame and a sense of failing to uphold some expected standard. Whether it was something private made public or a deviation from the “perceived normalcy” of the feminine body (Nosek et al., 2010, p32), these were situations that clearly had an impact.

I find it embarrassing sometimes when you're suddenly having a hot flush. Where I work we have to put on gowns if you're doing a dressing or when the docs come round, and sometimes we have to work in rooms that are more heated ... sometimes I'll be talking to someone, looking at them and I can feel myself going 'oooohhhh' and yeah I find that a little bit embarrassing ... I just try and ignore it and just carry on having a conversation or whatever I'm doing cos if I'm sterile they can't do anything anyway. I can't touch anything or wipe my face. (Yvonne)

Hot flushes, when observed by others, meant the women were publicly exposing themselves as being menopausal. The need to ensure they were “keeping up appearances” at work was an ever-present concern (Kittell et al., 1998). Dillaway (2011) concluded that where women were keen to conceal or hide their hot flushes when undertaking their paid work, it was related to a feeling that this physical show of being menopausal was somehow unacceptable in certain social settings. Concern was evident among many of

the women interviewed in this study, particularly in relation to patients or colleagues observing them mid-flush. Describing her experience of hot flushes within the work environment, Karen highlights her disquiet at her lack of control over when they would occur and how she would cope.

So the menopause was hot, you know. The flushes of hot in amongst my day when I'm more or less stressed and not knowing what's coming next ... being in the middle of CPR and you have a hot flush or you could be in the middle of putting an IV line in with the patient and all of a sudden you're like burning up. I have to say I can feel a little bit faint you know, when you feel too hot? And you know therefore my coping skills in amongst the environment was tested. (Karen)

As discussed in Chapter Two, Duffy et al. (2011) identified a key phrase from a participant (that was used in the study's title and was said to reflect the groups' discussions), that menopause was "... somewhere between a taboo and a joke" (p497), a concept still relevant to my current study.

Well it really is a bit of a taboo subject, we might joke about it but don't really talk about the implications of it ... which is why it strikes me as interesting to me that you would look at something that is actually very, very prevalent and yet not discussed and talked about. (Amy)

The women welcomed being able to discuss their experiences openly in what they determined a safe environment, possibly because in those moments their recalcitrant bodies were "normal" for their life stage (Dillaway, 2011 p204). Recalling seeing others having difficulty with something they struggled with themselves, such as hot flushes, mood swings, tearfulness or heavy bleeding, the women wanted to share their feelings, resulting in what Yvonne described as a kind of "sisterhood". The importance of this encouragement, reassurance

and support among women is widely recognised (Lesser et al., 2004; Dillaway, 2011; Sergeant & Rizq, 2017; Morris & Symonds, 2004). Being able to share things that have worked for them (such as particular supplements or other ways to address difficulties) was important for the women in this study. Describing how they valued the support and acknowledgement that what they were experiencing was normal, the women could openly laugh and joke together.

... sometimes you can joke about it but other times its actually really horrible so then it's quite nice that we support each other, you know we get each other a cold flannel, or turn a fan on....
(Karen)

It does help, even just understanding that you can have an off day and you can say I didn't have a good sleep last night cos I was hot, and they'll say oh God, have a cup of tea, you know (laughs). (Eve)

Humour was employed by both women and their colleagues in situations where hot flushes were apparent in the workplace. It was commonly used to deflect the discomfort felt by both the woman experiencing the hot flush and of those around her. Crawford (1989) found women's perception is that a good sense of humour "breaks social tension, eases another's unhappiness, and cheers rather than wounds" (p159). More recently Holmes (2006) argued that both men and women in the workplace used humour that "reinforced negative or restricting gender stereotypes", while also noting that women were willing to dispute and question humour that relied upon gender stereotypes that were to their detriment (p47). How comfortable the women in this cohort were with using humour varied.

Um, a little bit embarrassing. You know in the odd meeting someone's been having a joke with me and I've suddenly gone bright red and I try and say just a power surge we'll be right. Most

of the people I work with are really good, they're nurses, and the docs that I work with laugh 'oh you're getting old' they go (laughs) which is nice (laughs). (Eve)

Appearing to be relaxed when her colleagues commented on her hot flushes while linking them with ageing, Eve's reference to finding her hot flushes "*a little bit embarrassing*", together with her own laughter about it would suggest that she is not entirely comfortable with the interaction she recounts. It seems that it is less the physical feeling of the hot flush itself that is of concern but rather its visibility (Dillaway, 2011). Research on humour in the workplace shows that positive humour can contribute to team unity. Humour has been recognised as helping to ease what otherwise could have been "stressful or awkward interactions" while at the same time "reduc(ing) social distance between team members" (Mesmer-Magnus & Glew, 2012, p175). Humour does however require both parties to find something amusing in the exchange. If they do not it can result in a situation where one of the contributors (if not both) feels hurt or upset by the exchange. In contrast to Eve's apparent acceptance of humour, others like Hannah were less than happy with their colleagues' responses to their predicament.

I'm quite open about it. When you're having a hot flush and you try and talk about it but like they're too young ... they don't understand, like it's miles away for them and they just laugh. And like it's not nice, they're just laughing ... but it's like a funny thing and it's actually not very funny when it's happening to you. It's actually really horrible. Your moods are all over the place and I don't deal with ... it's frustrating ... and I guess that's what I'd like people to understand. It is like a joke to people. They think your mood swings or your anxiety are funny ... and it's not like it's a nice experience. (Hannah)

The make up of the team members appeared to determine how comfortable the women in this study were to bring, or have brought by others, humour to

the situation. For some, like Hannah, it was the age of her colleagues that established their perceived level of understanding. For others it was about the team dynamics that were already in place, with several noting that they would never discuss menopause with certain people as they felt their colleague would not have been empathetic.

...my feeling is, within the workgroup, workforce, there are a lot of people working under immense stress due to being menopausal ... I think there probably are ... who are really struggling through the day. ... The other thing too is, I guess I'm interested in what men's perception is of it, do they think it's hilarious, do they joke? We don't tend to joke about it with guys because again it's about feeling a bit foolish. (Teresa)

Dillaway, (2005) argued that mid-life women must confront the idea that their changing bodies in some way challenge the socially constructed “feminine/gendered” body ideal (p4). Concern in relation to how others responded to their visibility of being menopausal was evident among the nurses I interviewed. Teresa’s comment about feeling “a bit foolish” in front of men indicated that in some way she was uncomfortable with how she felt when aware of the “male gaze” (Dillaway, 2005, p4). Exposing the usually private experience of female bodies in a public situation was embarrassing for the women and when males are present this intensifies the “awfulness” of the encounter (Stephens, 2001. p661).

Humour can sometimes bring a team together, although the potential for hurting or upsetting workmates is also usually present (Holmes, 2006; Mesmer-Magnus & Glew, 2012). The women’s experiences of others highlighting visible signs of menopause emphasised the need for colleagues to remain mindful of how women may feel about this. It is hard to think of any other situations where it would be thought appropriate to comment on a colleague’s bodily functions for humorous affect. As the women continued to come to terms with their embodied menopausal self in the workplace it was

apparent that the people they shared their work day with had an influence on the quality of their daily experiences.

Summary

Although how their body reacts to menopause is a very personal thing, this cohort of women were experiencing it in a very public way and in a shared space observed by others. As noted earlier the workplace is not a welcoming space for the leakiness of women, and the responses of others can therefore play a large part in how women decide to manage their recalcitrant bodies in that setting. The lack of open discourse around what is often kept private must be challenged. Where the women felt safe and trusted their colleagues, they were more open to sharing what they were experiencing. This was clear when the women talked about their relationship difficulties. By encouraging mid-life women to discuss their experiences of sex more openly, the breadth of different experiences can be shared thereby confirming that while each woman's journey is unique, there are commonalities within these experiences.

In the next chapter I will consider what the "rules of engagement"⁶ are for menopausal women working as nurses. Using Hochschild's "Feeling Rules" (Hochschild, 1983) to explore how the women made sense of what was happening for them, both as a menopausal woman and as a health professional, I will consider how the women saw themselves, how they made sense of things and how they thought they should be seen.

⁶ This is a military term that essentially refers to unwritten rules that determine what information is given, at what time, to whom, and in what manner; and what concession is granted and what is demanded in return.

Source: <http://www.businessdictionary.com/definition/rules-of-engagement.html>

Chapter Five - Constructing a Menopausal Identity

Because the impressions people make on others have implications for how others perceive, evaluate, and treat them, as well as for their own views of themselves, people sometimes behave in ways that will create certain impressions in others' eyes.

(Leary and Kowalski, 1990. p34)

When talking with the women in this study about their experiences of menopause, it was apparent that they had not only encountered embodied changes but psychological and behavioural ones as well. As Leary and Kowalski (1990) note above, how we are seen by others, how we see ourselves and how we think we should be seen are all intrinsically linked. Impression management occurs in social situations where individuals place high importance on presenting acceptable images of themselves based on how they think society thinks they should act in a particular situation (Goffman, 1959, 1990). Hochschild (1983) further developed Goffman's idea of impression management but focused more on the emotional work involved in how people present themselves, particularly in the workplace. Hochschild (1983) described what she called "feeling rules" explaining that this was the divide between what someone actually feels about something and what they think they should feel. It also refers to unspoken social covenants that exist in our everyday interactions. By considering both impression management and feeling rules, the idea that women begin to construct a new or changed identity during menopause emerges.

This Chapter will reflect on influences that may impact the women's construction of their menopausal experience. Drawing on Goffman (1959, 1990) I will begin by considering stigma and the perception of others, noting that it is the wider social context within which the women in this study, and their families and work colleagues live that helped to shape their view of their world, particularly in relation to how they chose to be viewed within it. I then explore how the women came to construct their knowledge around what was

happening for them in relation to menopause, how they made sense of things by seeking information from a number of sources and then used that to assemble or confirm their identity as a woman experiencing menopause. To conclude this chapter, I will use the concept of emotional labour, which Hochschild (1983) defines as “... the management of feeling to create a publicly observable facial and bodily display” (p7), to show how the nurses worked to maintain the image of a caring professional, despite the emotional challenges they were facing.

Stigma and stereotypes - how do others see me?

How society views older women weighed on the minds of many of the women in this study, particularly due to the stigma associated with menopause and ageing in general. They were on a personal journey through menopause in relation to coming to terms with the changes they were experiencing, making peace with their menopausal body, as well as reflecting on a shift in how others viewed them. However, their individual constructions occurred within the social context of their lives, at a time when the link between menopause, ageing and subsequent loss of perceived status is still very much an issue for women (Dillaway, 2015; Rubenstein & Foster, 2012; Chrisler, 2011; Strauss, 2011).

While movies do not represent the real world, we do know that the media often portray negative stereotypes of older female characters and this can be influential in shaping attitudes to mid-life women (Lauzen & Dozier, 2005). Similarly, Bazzin et al., (1997) have argued that what we view on our screens is not only a reflection of the attitudes and beliefs of a culture but also reflects what we would like to see as reality. They concluded “... to the extent that consumers digest such material as truth, rather than fiction, the depictions laid forth by the media can be influential in the propagation and maintenance of stereotypes” (p532). Reflecting on how the media in America portrays women, the following quote from the Boston Women’s Health Collective (2011) is also relevant to New Zealand.

Many women chosen to play mothers are often the same age or younger than men playing their sons. The older women you do see often look much younger thanks to careful casting, plastic surgery and digitally altered images. As a result, those of us who choose to age naturally, without the aid of plastic surgery, meticulous beauty regimes and restrictive dieting are sometimes seen as “letting ourselves go”.

(Boston Women’s Health Collective, 2011. p60).

This focus on the loss of youth and (by association) fertility, particularly in relation to menopause, means that once women have reached this stage “... culture seems to say they are no longer interesting” (Chrisler, 2007, p8). Talking informally post-interview, several participants in this study mentioned how important exercising, trying not to put on weight and dressing smartly was for them. The inference was that they did not wish to be seen as either frumpy or as having let themselves go, an attitude that is commonly mentioned by women discussing menopause (Sergeant & Rizq, 2017; Rubenstein & Foster, 2012). Consequently, many of the women were concerned about how others viewed them, often feeling judged in comparison to younger people. This was especially apparent when women worked with younger colleagues.

You know when I was younger it was like, how could you have that happen? It’s not going to be that bad. And now that you’re actually in it you think no, I’m not the same as I was. Things ... I don’t bounce back as easily. So I don’t think the young ones ... it’s a concept, it’s not a reality for them. (Beth)

Howell & Beth (2002), found that many women struggled to reconcile their perceptions of middle-aged women (which were almost always negative) with their view of themselves, noting that until this happens women cannot move towards mid-life acceptance. Several women in this study changed the way they talked about certain things in their workplace, including menopause, because of this unease. They assumed that if they did not talk about menopause, colleagues were less likely to think that they were menopausal,

thereby avoiding the negative stereotypes and consequent stigma or “undesired differentness” mentioned earlier (Goffman, 1990, p15). Stigma occurs when individuals have some quality that marks them out as different from others (Goffman, 1990). It is a socially constructed phenomenon which creates a divide between those who conform to norms and those who do not (Chrisler, 2011). Seeing stigma as relating to an individual’s perspectives, Goffman (1990) believed these could change depending on context or life stage, something that was in a state of flux for the women in this study.

Shilling (2012) proposed that we are inclined to observe our bodies “as if looking into a mirror which offers a reflection framed in terms of society’s views and prejudices”(p88). Although there was a sense of “it is what it is” (Beth) among some of the women, others recognised that there was an element of choice in not only influencing how they were perceived but also in how they chose to react to the changes they were experiencing. Carrie aligned riding her mountain bike with challenging the perceptions and expectations of others who may identify her as being older, and therefore riding a bike seemed less likely. As Carrie explained, how you choose to behave is not necessarily determined by your age or others’ expectations of what is appropriate.

... just because you're getting older doesn't mean you have to act old. Like falling off my mountain bike on the weekend so it just takes longer to get better, yeah it's still fun though. (Carrie)

The way someone undertakes activities, how they behave in certain situations and what they say in front of others all contribute to creating an explicit influence on their audience (Guadagno & Cialdini, 2007). For many of the women I interviewed, this was particularly obvious in relation to undertaking further education. Postgraduate study is common among nurses and several of the women I interviewed were studying at the time.

Even when there was no actual requirement to undertake study, the pressure to do so often appeared to come from the women themselves. With many of their (often younger) colleagues having higher qualifications already, the decision to study for some women reflected a fear of not keeping up. Teresa was studying and although she acknowledged the stress it placed on her, the way she responded to this caused her to doubt herself.

I know it's just this massive pressure, and no I shouldn't say that because actually, I don't have to do my Masters. But I'm surrounded by women in my team who have, so there I'm pressurising myself really. So I really only have to have my postgrad diploma, which I've done so, there's this thing ... Um, this year I got really wound up about the um last paper I've just done because there are two exams and I was really, really worried about retaining the information. Because you know, writing an essay I, I get hung up on stuff there but to swot ... Study was really difficult and I did ok um, I don't know how the hell that happened, but it was ok. That really stressed me out, I got really stressed to the point I felt tearful in the exam which is so not like me, and it's not what I thought I was like but... (Teresa)

Whether or not they chose to complete postgraduate study at times appeared dependent on not just what their colleagues were doing, but also the time required to study, what commitments they already had outside of work, future work plans (certain roles may require postgraduate qualifications), lack of financial incentive and whether they could see any benefit in doing so.

I've decided I've applied for a few jobs this year and both times I've missed out because the other girl had Masters Papers but I've decided I'm not doing any more, you get over it. I've done enough.

You don't get paid any more money for doing all these papers so what's the point. I do enjoy them and I enjoy learning and building on my knowledge base but I've got really negative lately (laughs).
(Yvonne)

Studying while being menopausal was a challenging and stressful competing demand for time, although study, as Marie notes, is almost always stressful anyway.

...with study it goes with the territory of studying and stress and I don't know if menopause has made a difference at all, if it's had a difference at all. (Marie)

As mid-life women, interactions with their less subtle colleagues clearly intensified the awareness of getting older. Following one such interaction with a registrar, Teresa's stress undoubtedly heightened when he appeared incredulous that she, as an older woman, was indeed studying. Goffman (1959) identified that in our interactions with others there is an implicit request that others regard us seriously. To not do so is in violation of that implied request and results in a perceived slight by the person affected.

I don't think it's about whether you're going through menopause or not. It's just that you're in your 50s and it is, you're already in that ... The other day, well a month or so ago when I was still doing my paper, I was talking to one of the registrars. I asked him a question related to my essay and he looked at me in absolute shock. He couldn't believe that I was doing postgraduate study. "Oh, what are you doing that for? Why are you doing that?" and he couldn't believe I was doing my masters and a clinical paper. And I was thinking I was shocked that he was shocked! And I thought do I look that old? It was really amazing and yeah, so I suppose I do feel slightly judged for my age because in the wards there's younger ...

it feels like there are younger nurses. But that's ok I need to sort that out myself, that's my issue. But he was shocked that I was doing postgraduate... (Teresa)

When reflecting on the registrar's comments Teresa responded by asking whether she looked that old (that he would see her as too old to study), and then felt judged for her age. Teresa appeared to consider that it was not the registrar's comments per se that were the issue, rather it was how she was feeling about them and her age that was something she needed to come to terms with. Her experience was not consistent with her expectations of a discussion between herself, a senior nurse undertaking postgraduate study, and a younger work colleague. As a result, it left her trying to make sense of the situation, a position many of the women found themselves in.

The term "impression management" describes an individual's attempt to influence how others see them by regulating and controlling information during social interactions (Goffman, 1959). Teresa's subsequent embarrassment, if not humiliation, in relation to the registrar's comments, is something that Goffman (1959) warned was a possible outcome of any social interaction. He proposed that successful impression management occurs when the audience (in Teresa's situation the registrar) aligned with the individual's (Teresa's) perception of self. Goffman argues that in all social situations people choose how to present themselves dependent on what they believe as appropriate for the particular circumstances they are in. If the two audiences have differing views on what that looks like then a degree of dissonance will occur, as it did for Teresa.

When women encounter a situation where the persona they believe they are presenting is not perceived by others in the same way, it causes them to question why that is so. Impression management generally occurs in a considered way, rather than employed for misleading purposes (Leary, 1995). The disparity between how the women in this study perceived their presentation and the reality of how others actually saw them caused a degree

of self-reflection to occur. This was particularly true where women felt they were not presenting in the way they wanted to. Several women recalled past situations and reflected that their behaviour “was not like them”, and they appeared confused that they were not behaving in a way in which they thought they should, therefore struggling to manage impressions. In some cases, they disassociated themselves from their behaviour with comments such as Beth’s “*I can hear myself saying it and it’s like oh my God, that’s not me, that’s not what I’m normally like*”. Here Beth talked of herself almost as a separate entity, as if she was watching on as an observer. In contrast to this, Hannah’s approach was more analytical, trying to understand why she was behaving in a certain way.

...that’s the thing that worries me the most. I don’t think I’m losing the plot but I just think why did that upset me, why am I not handling this and it’s good to hear that that’s normal. ... And you can’t help being erratic. I guess that’s what I’d like people to understand. (Hannah)

Morris & Symonds (2004) found that issues during menopause can sometimes become the focus for a lack of control women may be experiencing in other areas of their life. They labelled this “blame shifting” and noted that some women struggled to uphold an appearance of things being normal, especially at work, because of this. (p316). Their study identified that this was often the prompt to search for information and guidance from a range of sources, something the women in this study also did.

Making sense of it all

As mentioned in Chapter 4, despite their nursing training giving them the practical understanding of how the human body functions, many of the women in this study did not recognise that what they themselves were experiencing could be due to menopause. In part, this obliviousness could be related to the wider social context where discussion and understanding of taboo topics such

as menopause are limited (Chrisler, 2013; Nosek et al., 2010). Several of the women had friends or colleagues who were not interested in talking about their experience and their response to this was often to refrain from talking about menopause in situations where they were present.

(my boss) she's in her early fifties but doesn't really talk about it though. I'm really open about my hot flushes and that but she was the one that actually emailed me and said you might be interested in this (study). Obviously, because I had talked about it ... My other friend who isn't having trouble, she doesn't really want to talk about it either. (Hannah)

A common thread among the women participating in this study was the need for a definitive answer about what was happening to them. It seemed important to them to label what was happening, which at the same time would also clarify what was not happening. As Hochschild (1983) explained, “(t)o name a feeling is to name our way of seeing something, to label our perception” (p223). By doing this the women were able to begin the process of making sense of exactly what these changes meant to them, particularly in understanding the impact it may have on their sense of identity.

Initially, when I started going through menopause in the early stages, like 10 years ago, that was like perimenopausal and I didn't know what the hell was happening. I thought I was really going mad and I was paranoid and all that sort of carry on. (Carrie)

Well for me I started having some changes and feelings that I was having. So I sort of went to my GP and talked about it with my GP and said I need a blood test, you know. I need to know what's happening. And she was like no, no, menopause is one of those things that can take 10 years and I was like oh my God... (Karen)

Researching how women make sense of health information, Genuis (2012) found participants constructed their knowledge from across a range of sources, both formal and informal. Similarly when seeking information on menopause the women in this study gathered their knowledge from a range of places and people, often seeking out the views of other women (mothers, sisters, friends and colleagues) as well as approaching their general practitioner (GP). These discussions were often used to compare notes or seek advice, helping them clarify what was happening to them and, in many cases, how they would choose to deal with it.

Also a great sisterhood thing though, I can talk to women of a similar age about symptoms and they suggest well I'm taking this herbal or I'm on HRT, you know it does bring up some good conversation. Which is good, good camaraderie. (Yvonne)

Understanding what motivates health information-seeking behaviours, and within what circumstances such pursuits are centred, should be considered alongside the process people use to make sense of what they have found (Genuis, 2012). In relation to menopause, some of the nurses I interviewed described being a health professional as a disadvantage when it came to being objective about themselves (and what they were experiencing), sometimes having a tendency to think the worst whenever symptoms occurred. Marie worked daily with those who had cancer and recognised that tendency to go for the “worst case scenario” first.

Yeah well, sometimes knowledge is a great tool, sometimes not (laughs) knowledge can be a great disadvantage – I've got a headache, oh god I've got a brain tumour (laughs). (Marie)

Similar to the findings of Marnocha et al. (2011), in this group there was an obvious incongruence between the women's understanding of menopause and being able to recognise its manifestation within themselves, at least at the

beginning of their experience. This lack of knowledge as to what is “normative” can be linked in part to “unclear, contradictory and confusing information” (Rubenstein & Foster, 2012. p 304). Some women found being aware of their mother’s experience of menopause was helpful, however, most of the women in this study, for a variety of reasons, did not really know how it had been for them. Noting it was not something their mothers talked about, there was some discussion that even if they had shared their experiences with them they were not sure of how relevant that would have been to their experience, given how different things are for women now. This was further supported by Utz (2011) who found that although the experience of menopause had not really changed between generations, women’s attitudes and behaviours towards it had.

I still don't (know what mother's experience was). My mother is still alive and I have no idea. She's never talked to me about it, she doesn't choose to. And I don't see the value in that now either. Because times are so, we've lived completely different lives so I'm not sure it would add anything. What Mum was doing in her 50s is completely different to what I'm doing. She lived a different life to me so... (Teresa)

How women live their lives and contribute to society has continued to evolve, particularly since the advent of second-wave feminism in the years following the Second World War. As women began to challenge society’s expectations of their roles in the workplace and at home, new opportunities were becoming available to them (Utz, 2011). They sought greater participation in paid work, more information and involvement in decisions around their own health, and had expectations of maintaining their “vitality” as they aged (Setness, 2000, p11).

When interviewing two generations of women about their experience of menopause, Utz (2011) concluded that the social construction of menopause had indeed changed. The mothers and daughters in her study expressed very different attitudes towards both menopause and ageing, despite their

biological experiences being very similar. This generational difference was also highlighted by Isla as she explained how the perception of ageing had changed from her parents' generation to hers.

Yeah but like I don't feel old. To me that's just a number. I certainly believe you're as old as you feel, you can make yourself old. My Dad only died in his sixties but he stopped work at 65 and just sat around and curled up. I said to him you don't have that luxury Dad, it doesn't work like that but he was quite happy to go on and his was just an existence. Whereas my Mum, now she's at 76. She was still working in childcare right into her 70s, she wanted to keep doing it, you know gave her a bit of extra pocket money. She didn't want to, she only stopped work when she moved down here, and otherwise she would have still been working up there. She waited until she had four kids at school before she went to teacher's college. She was expected to have the housework and meals done as well. (Isla)

Not knowing about the experience of other women in the family really only becomes something for women to consider when they themselves begin their menopausal journey. Although menopause was not discussed or experiences shared across generations, sometimes when this would have been helpful it was too late, as it was with Eve.

No, my Mum had a hysterectomy when she was 25. She'd apparently had 5 miscarriages between my brother and me, and I don't know why she had a hysterectomy, to be honest. She died about 11 years ago at 65. So she said to me she went through menopause really early and I didn't note that she had any menopausal symptoms about the time that you would think. We had a really strange relationship, my mother wasn't very well... so yeah it's not really ever something we talked about. And I would have asked my Nana but she got dementia and she's since passed

away so I couldn't ask Nan so... But Nan would have talked to me about it because we had a really close relationship. But I often talk to my other girlfriends about it all the time, we lament you know like oh god its back again. (Eve)

Only one of the women (Yvonne) mentioned recording her experiences for her own daughter.

I think I used to ask Mum questions like when did you stop and she just couldn't remember which was disappointing. I was thinking I must write it down for my daughter cos I'm getting to the age when I can't remember (laughs) and when she's 50 and she wants to know. (Yvonne)

As identified in Chapter Two, menopause has been subject to a medicalised approach with a strong focus on physiological symptoms and their treatment. As a result of this women often seek out medical advice to assist with managing some of the issues they may be experiencing, often with mixed results (Rubenstein, 2014). As found in another study (Marnocha et al., 2011), most of the women I interviewed indicated that their general practitioner had not raised the issue of menopause but instead, it was them who started the discussion. Marnocha et al. (2011) went on to suggest that there was a case for better informing women before symptoms began and that this would help normalise the experience for them.

... I've just had a thought too actually. I've got a great GP but she never asks me (about menopause) and yet she is really great. She'll ask me about everything else she might think she needs to be checking up on but she would never, she's never asked me that. I'm wondering if she's younger than me and she hasn't thought about that as something and when she hits menopause she'll probably start asking me. Yeah but I think if I was a GP and I had women my

age I would actually say because it does impact hugely on your life. You know it really does so I would be, it's sort of like a mental health question isn't it? (Teresa)

I haven't actually (talked to my doctor). Surprisingly, I go to a female doctor and she hasn't brought it up with me. She always seems to be more concerned about my blood pressure than anything else and losing weight. I should probably bring it up. I think I need to go in there with a notepad and bring it all up, but you know how you go in there and they've got 10 minutes and it's all a bit rushed... (Yvonne)

Rubenstein (2014) found that many doctors now tend to consider menopause in a broader sense, acknowledging that although it is often described in medical terms, it does not constitute an illness. Rather it can be viewed as a natural phase, though one that where interventions are prescribed may be “risky” for some women (Rubenstein, 2014, p221). While noting that women approach menopause as a key time of change in their lives for which they want specific explanations and confirmation of normality, Rubenstein (2014) concluded that this was something that many doctors struggled to do. She questioned whether as a result women are now expected to tolerate a higher level of discomfort, resulting in some women missing out on being offered medication to help mitigate their symptoms. However, it was not clear whether offering medication would necessarily result in acceptance of it.

Inconsistency was evident among the women in this study in terms of how comfortable they were with taking medication to address some of the physical and emotional challenges they were facing (such as heavy bleeding, hot flushes or mood swings). Isla talked about how she put up with bleeding for four months and while she waited for it to stop was quite fixated (like others) on menopause being classed as over once the magic twelve months post the last period had been reached.

...from mid-December to mid-January I bled again for a full month... and it didn't abate, it didn't lighten up and then it stopped in February. And then I had nothing till August and I got four days of light bleeding and I thought um do you count that? So I'll go and see them (doctor) in February and maybe see whether they count the wee bit in the middle or if I've got to wait until August next year. But um I did ask, when I started stop-starting and that, if they needed to do my bloods and they said there wasn't any point as it wouldn't tell us anything. I thought he'd be able to see if my hormone levels were going down. (Isla)

Similarly, Beth was accepting of the “just hormones” explanation from her doctor for her experience of bleeding heavily, despite this leaving her at times unable to leave her house.

When I've been with certain symptoms like, in the middle of last year I was having problems like really heavy periods, irregular, more of them and it was awful. It was like what the hell is going on, I couldn't leave the house basically. So I went and saw her and had to have a (biopsy of the uterine wall) in June or July last year so I'd had 3 or 4 months of really shocking heavy... So we talked a little bit about it and she said it's probably just hormonal and I'm just like oh yeah, whatever. Definitely wasn't anything sinister, so probably just hormonal and then I only had one or two more periods after that and it was gone. Whether it was a last hurrah I don't know (laughs). (Beth)

Several of the women had gone on to Hormone Replacement Therapy (HRT) and found that it was very helpful in resolving their symptoms, although they appeared conflicted about taking it due to possible side effects. The lessons of the Women's Health Initiative (which linked HRT use with increased risks of breast cancer, blood clots, stroke and heart disease) appeared fresh in their minds (Writing Group for Women's Health Initiative Investigators, 2002). One

woman spoke of her GP saying she could take HRT for a maximum of one year only, while another said her mother was still taking HRT at 78 years of age. Others had tried it for a while but stopped taking it for a variety of reasons. These included a twin sister developing ovarian cancer (considered a risk factor for taking HRT⁷), one said she was not very reliable at taking medication regularly while another one felt her symptoms had resolved and she did not need it anymore so came off it after three months.

He was great. I went to him and said look I think I'm going crazy. I'm just so tired, I can't sleep. I just feel like I'm too sleep deprived to be able to concentrate. And he said there are three things you can go and do. I could go on HRT, I could go on an antidepressant, I can't remember what that was, or I could take a mini pill type thing. And I said oh look let's just try HRT. I'd heard from my friends that as soon as you start taking it, it stops things pretty much. ... I took them for a month and within three days they'd (the symptoms) gone and I slept like a baby and I felt like a new person again. (Eve)

In contrast to this, others were reluctant to go down a medicalised treatment approach. Saying menopause was a natural part of life and they were not unwell, they preferred to manage with natural remedies.

No, no. I mean it's annoying and that, the tiredness and that, but I'd rather manage, like with the natural side of it than go down the other ... (Hannah)

⁷ Source: <https://www.healthnavigator.org.nz/medicines/m/menopause-hormonal-therapy/>

After her experience with HRT Eve had also decided that her symptoms were manageable without it.

Yeah we [friends] do, we have a few laughs about it. We talk about what works. Pretty much none of us are on HRT. We're pretty much trying to do things naturally because we're aware of the side effects of it. We recognised why people would use it like I did and its certainly worth it um, just to keep you sane. (Eve)

Although there is still much debate around the best approach to managing the issues associated with menopause, the process of making sense of what is happening is still an individual journey (Stephens, 2001). Seeking advice and information to help provide some clarity around menopause, women were often at the same time “functioning within a mass of contradictory feelings and attitudes” (Morris & Symonds, 2004, p319). Taking the opportunity to make choices about how they would respond to menopause appeared a positive way of taking back some of the control over what they were experiencing. This enabled a focus on menopause as a process rather than the usual medical definition emphasising an event (when menstruation stops) (Lupton, 2012). This sense of taking back control and being in charge of how they outwardly presented themselves was particularly important for these women in relation to their role as a nurse.

Being (a) professional

Nursing has a very public face. There is an expectation that nurses will present a caring professional persona to both patients and colleagues, which makes it difficult when menopause intervenes (Gray, 2009). Speaking of how difficult it was at times to maintain that professional façade, with menopause affecting their ability to work coherently and remain focussed on the task at hand, the women in this study reflected on the need to remain in control (or at least appear to be) in the workplace.

Yeah, so you're at a peak where you have to be able to respond at any time so you have to be at an alertness ... and so you're all, you have to be calm and stuff. You have to be able to act quickly, cos someone will do something right beside you and you know like a seizure or um fall over. Or you hope they don't but you've got to react quickly. (Karen)

Goffman (1959) described his “dramaturgical model of social life”, using the theatre as a reference point to explain how people engaged in social interaction are constantly trying to present themselves in such a way that they do not cause embarrassment to themselves or to others. While Goffman’s work centred more on the social and cultural influences of social interactions, Hochschild’s (1983) focused on the workplace. She identified that Goffman’s model could not explain “display work” such as why it is important for flight attendants to smile or to ensure the tone of their voice is appropriate (p10). Hochschild (1983) saw the role of emotion as being pivotal to interactions in the workplace, describing how its manipulation could produce the appropriate response when required.

“Emotion, it is argued, can be and often is subject to acts of management. The individual often works on inducing or inhibiting feelings so as to render them “appropriate” to a situation”.

(Hochschild, 1979. p551)

Hochschild (1983) describes this process as emotional labour, where feelings are evoked to “sustain the outward countenance that produces the proper state of mind in others, in this case the sense of being cared for in a convivial and safe place” (p7). Although in this instance Hochschild was talking about airline flight attendants, this could equally apply to the expectations of nurses to provide care and support to their patients. Emotional labour is seen as an integral part of caring and has been identified as best practice nursing, “part and parcel” of being a nurse (Gray, 2012. p48). In asking nurses to define what emotional labour meant to them, Gray (2012) found it was viewed as a key

part of their role in “making patient’s (sic) feel ‘safe’, ‘comfortable’ and at ‘home’.” (p47). The challenges of menopause can interfere with the ability to perform that caring role. As nurses who undertake emotional labour as part of their normal routine, the women in this study faced identifying what Hochschild (1983) referred to as their “redefined self” (p132). She argued that it was necessary for workers to determine the separation of the individual (real) self at work, in comparison to the role they undertake (act) in a specific workplace (thus identifying their private versus their public selves). This meant acknowledging the conflict that comes with knowing the requirements of how to behave in certain circumstances despite not always either wanting or being able to behave that way (Hochschild, 1983).

... When someone has got intense passion, sometimes they lose control ... I think that’s how menopause is. You have a certain amount of control but ... when that switch flicks (pause) there’s no control... That’s what it was like for me and that really scared me ... Yeah, because we’ve got to be seen to be professional. And honestly that’s a word I hate with a passion because what about us, as human beings, that’s what we are first and foremost. (Carrie)

Carrie’s disdain for the idea of having to be seen as professional is aligned with what Hochschild (1983) termed a fear of “being phony”, describing this as where someone “wants to put her heart into the work but can only lend her face to it” (p134). This describes many of the women in this study, especially when at the same time emotions at a personal level were challenging. For some this was a very clear-cut situation where there was no in-between. You were either at work regardless of what was happening or you were at home.

Because menopause is a funny thing, because I’m not going to be able to say I’m really sorry, I’m not going to be able to do my shift today because I’ve got these terrible hot flushes and I just feel like I’m going to, you know ... They’d look at me like, come on just get up and get on with it ... In my job, you’re either working on the floor

or you're not, and if you're not working on the floor then you're at home – there is no in between. It's quite tricky like that ... It's like well we don't have an alternative for you so you get out there and work with your patients. (Beth)

Recognising that changes in behaviour could be related to menopause was helpful but the pressure to maintain the professional persona at all times was strong. It seemed that often they compared themselves to others who appeared to be coping well and, as a result, maintaining control was crucial. Emotional labour was not only being used by the nurses to present themselves professionally to their patients, it appeared to also be a way of concealing from their colleagues how they really felt on occasion in the workplace. This contributed to the lack of openness surrounding menopause at work, particularly when not all of the women were prepared to share their experiences with their colleagues. This was something Eve was obviously aware of when asked what advice she would give to other women in her situation, that is experiencing menopause.

Look after yourself and don't try and be a martyr and box on through. And we tend to as nurses. We think we'll be right, we'll be fine. We're hard on ourselves and we should be able to say look I'm really struggling with my sleeping at the moment, forgive me if I'm not on my "A" Game. Please let me know if you're worried, if you think I'm really off. Just be honest about it, tell someone you trust. If you can't tell your manager, tell someone else in your team and ask them to have your back, because some people are extremely unkind. Women are extremely unkind to each other when they aren't on their "A" Game. (Eve)

Having a clear understanding of the expectations of working as a nurse, when something happened in the workplace that challenged the women's view of their "redefined self" it caused a great deal of stress (Hochschild, 1983. p132). As mentioned earlier the nurses I interviewed were quick to disassociate

themselves from their actions, saying that was not who they were and that they could not control their behaviour.

Sometimes, and I think its tiredness and not feeling rested, it does have an impact. I can ... I know some days I'm a bitch when I'm at work and I hate that. I'm like, oh I can hear myself ... It's like you just have to stop and let that, it's like that moodiness... It's easy to snap but if you've got like four sick patients in resus, you've got someone asking you for help and you're barely getting through what you need to get yourself through normally, it's hard. But it is what it is, but some days I get really snappy, and I can't help it.
(Beth)

It's learning to acknowledge that because it's your hormones doing it that's why I'm more stressed or why I fly off the handle. It's being able to recognise those things as a possibility because I know (from previous hormone therapy) I could feel myself getting angry which was not like me at all. I wasn't a yeller, but I knew that if someone pushes my buttons today they'll cop it ... I probably had an issue earlier in the year, could it be connected to being menopausal? I don't know but we'd had an incredibly busy night shift with just two of us on ... and it got to the morning and we'd had such a busy night and I sat there howling, and I don't do that ... (it is) very out of character for me. Could you relate it to menopause? Don't know, it could have been that I was at the end of my tether, um cos it had been the night from hell but it does take a lot to push my buttons...
(Isla)

Ashforth & Humphrey (1993) argued that identity plays a key role in emotional labour, saying "the more central a given role or group to one's identity, the stronger the association between one's emotional well-being and the perceived success, failures and demands of the role or group" (p106). An important part of the identity of the women I interviewed was being a nurse,

with one woman (Isla) going so far as to say “my nursing is my life”. They understood the perceived expectations of the “professional” nurse, and even when they struggled, the need to remain vigilant to maintain the façade was clear, as Carrie explained earlier.

Part of being a good nurse is having a good relationship with patients, something that requires both a robust professional identity and a confident self-perception (Ohlen & Segesten, 1998). When the women in this study spoke of how being menopausal had impacted on their interactions with patients, the importance of having a strong professional relationship with them was evident. Where there was a mismatch between the level of care they wanted to provide and what actually happened on a shift, they were often quite distressed.

Oh God yeah, you know leaving work feeling like I'm a bad nurse, feeling like I hadn't done a very good job, being all task-oriented and you know shuffling out the door as patients tried to share their emotional or whatever is going on for them. You've got three or four other patients that are needing medicines or the phone's ringing. It's very challenging when there are competing demands on your time. (Marie)

It can be a bit much sometimes. We have found in the past when all of us were so, so busy that we were really task-oriented. That we were all getting burned out because we weren't able to be the calibre of nurses in this particular area that we want to be. Sitting down and just holding a hand even if it's just for a couple of minutes, that makes a huge impact on the patient but also is hugely impactful on us as well, it helps to give back to us and helps to fill us to be able to go and given help to the next person. (Amy)

Hochschild (1983) recognised what Marie and Amy described above as a situation where the “real” and “acted” parts of a worker are tested, making “personal service impossible to deliver because the individual’s personal self is too thinly parcelled out to meet the demands made on it” (p133). The extra winter workload pressure that Marie was experiencing in her workplace was on top of the added stress she was under in relation to menopause. Similarly, Amy explained that it was not just menopause that added to this stress. Hochschild (1983) observed workers distancing themselves from their work to maintain their self-respect in the face of this dissonance (between who they were and who they were in their role at work), saying “the job is the problem, not us” (p135). However, like Marie, the women I interviewed tended to take things more personally.

Summary

This chapter has reflected on how the unspoken rules that govern interpersonal interactions have an impact on the women’s construction of their menopausal self. At times the women I interviewed struggled to separate who they were and how they were feeling as a menopausal woman, from their role as a nurse working in a hospital, with all the expectations of caring and remaining professional that go with that (Ohlen & Segesten, 1998; Gray, 2009). By deconstructing some of the elements involved in this process, we can see how women assemble and validate their identity as a menopausal women.

Using Goffman’s (1959; 1990) stigma and impression management theories, I have shown that how they are perceived by others is important to the women in this study. Exploring how their strong desire to make informed choices has influenced the progression of sense-making, I have identified that the often incongruous viewpoints that surround menopause makes this process more difficult for the women (Morris & Symonds, 2004).

Finally, I have considered how the nurses may have employed emotional labour to address their concerns in relation to both how others see them and how they believed they, as professionals should be seen. While the women in this study's perception of themselves appeared closely linked to their identity as a nurse, it was clear that responsibilities outside of their paid work also had an impact. The next chapter explores what other roles the women undertook that may also have had a bearing on their "redefined self" (Hochschild, 1983, p132).

Chapter Six - Being All Things to All People

Menopause creates tension between a woman's expectations, social expectations, and the particular realities of each woman's circumstances.

(Stotland, 2002, p5)

Mid-life does not occur in a vacuum, meaning the women in this study were not experiencing the menopausal transition from one life stage to another in isolation. Outside of work they were also wives, mothers, and daughters, leading to some uncertainty and at times tension, in relation to the changing expectations of others. The importance of women integrating these various roles, in a way that was meaningful to them, is seen as a key undertaking of mid-life (Clark & Schwiebert, 2001). Where women are experiencing other changes alongside menopause, the added stress involved means their capacity to cope with everything will be tested (Dare, 2011). To understand some of the complexity encountered in this process, this chapter will begin by considering the concept of the so-called "sandwich generation", defined as the "adult children of the elderly, who are "sandwiched" between their ageing parents and their own maturing children" (Miller, 1981 p 419). This situation can generate considerable stress for those in the middle of the "sandwich", especially when they are also coping with menopause.

Using Hochschild and Machung's (1989, 2003) concept of the "second shift" as a framework, this chapter will then reflect on how being part of the sandwich generation has helped to shape the women's accounts of their lives as menopausal women. When Hochschild and Machung (2003) first wrote about the "second shift" in 1989, they described the increasing numbers of women who had joined the workforce while at the same time continuing to do the housework and bring up the children. Although Hochschild and Machung's work focused predominantly on the division of labour within households, the concept can also be used to consider the second shifts that occur across households, either in relation to ageing parents or adult children. Within this

the impact of the “empty nest” and “boomerang children” (Mitchell, 1998 p21) will also be discussed. To conclude this chapter I will then return to Sergeant and Rizq’s (2017) “opportunity to review” (p10) to explore the women’s process of understanding what life could be like for them going forward, post menopause.

The sandwich generation

Referring to the “sandwich generation” has become part of our “everyday lexicon”, in use across government papers, academic writings, the media and the phrase even has its own entry in several dictionaries (Burke & Calvano, 2017, p3). First used in published literature by social worker Dorothy Miller (1981), the term referred to the stress that could arise when cross generational support was required:

“The position of the children of the aging in relation to their parents, children, and grandchildren exposes them to a unique set of unshared stresses in which giving of resources and service far outweighs receiving or exchanging them. This imbalance occurs just when the middle-aged members of the sandwich generation are themselves confronting major personal developments such as loss of youth and concomitant recognition of their own incipient aging as well as the impact engendered by the so-called empty nest. Many of this group have arrived at a time of relative equilibrium in both their economic situation and their marital and personal relationships. They are ready for relaxation and self-indulgence, only to find that their grown children are not quite independent and their parents have moved from autonomy to a degree of dependence” (p419).

In 1981, Dorothy Miller wrote about an industrial (American) society where four-generational families were becoming increasingly common (Miller, 1981). In the years that followed, the average age of women giving birth increased, meaning women are now frequently still working with dependent children when their parents are reaching an age where they require some assistance. As a result, four generational families are no longer the norm. Although not mentioned specifically by Miller, this has also resulted in menopausal women often finding themselves in the situation she describes

above, as was the case for most of the women in this study. This perhaps also reflects the increasing age of women having babies. In New Zealand the birth rate for women aged 35-39 years has continued to increase since the mid-1980s (Statistics New Zealand, 2008). Women in this age range will be between 53 and 57 when their child reaches 18 years of age.

Many of the women interviewed talked of having ageing parents and, with only one exception, children. Although they were at different ages and stages, those children were all contributing in some way to a heightened level of stress for their mothers. Undoubtedly having adult children while experiencing menopause brought its own issues; however dealing with teenage hormones while coping with their own fluctuating ones was also an issue for several of the women.

Does it mean I'm being less tolerant? I think I hear myself being less tolerant. I have a teenage daughter. A menopausal mother and a teenage daughter. We have the same birth signs as well, the same personality – would that be related? It's hard to know ... (Isla)

It is important to acknowledge that the stress of ageing parents at mid-life remains for those women without children as well. This is especially true where their siblings may have children and consequently view the childless woman as being more available to take on a caring role as they “only worked and did not have families of their own” (Rubenstein et al., 1991, p S273). This appeared to infer that if a woman did not have a family herself she would be available to assist those who did, regardless of other commitments, including work.

While menopause itself can be a cause of stress, it often coincides with other stressful life events. Simpson, (2016), found that women who have greater stress during menopause are more likely to experience psychological distress. The added stresses and time commitment of dealing with a range of issues

with either their children (both teenage and adult) or their parents (or parents-in-law), was common among participants, and many experienced both. Teresa was an example of this, juggling teenage children, an elderly mother and a mother-in-law with dementia.

Yeah ... because I've got an elderly mother and I've got, well my sons are teenagers now, but I've got two who're constantly, not constantly that's not right actually, they're not so bad now. You, you've got, you constantly think about them and I've got an elderly mother, and I've got a mother-in-law, you know she's not married but she's got very severe dementia, who we see every night. And um yeah anything to do with family will impact on me, if there's something worrying me about family. (Teresa)

The complexity of all the different responsibilities and expectations faced by these women was also obvious when I asked Karen about other things going on in her life during menopause.

Hmm, it's hard to know, we all do have other things. I've got children and grandchildren, and elderly parents that have been sick and stuff and there's all the earthquake stuff over the last five years. And it's hard to know how that impacts on you. (Karen)

In a study of women with multiple roles (in relation to parents, children, partner and work), Stephens et al. (2001) found that the conflict between those roles affected both the level of stress that the care-giving for parents caused, and the impact on women's psychosocial well being. For many of the women interviewed those extra roles required a significant amount of time.

Yeah but I think my kids, these take up less time now, obviously, and um, well not obviously but they do, you know they're away from home. It's now older parents, I was just saying the other day that

probably one day out of my weekend is spent with a parent, with older parents, so yeah that's a huge time commitment with me.
(Teresa)

Hmm it's all the sorting out and then there's the money thing as well. Jeepers creepers, and now I'm trying to fill out the form for a residential subsidy form thing for Dad to go to WINZ because I thought the house was in both their names but it wasn't, and I assumed it would all go to him but it didn't. Only half went to him and the rest went to my sibling and I, and that really threw me, thanks Mum (laughs). (Yvonne)

The impact of undertaking a multiplicity of roles was also evident for Yvonne whose mother had died in the previous year, with the subsequent support for her father involving a variety of undertakings. The stress of this combination of events had been building up to such an extent that she was looking for another job, although in the meantime she had reduced her hours of work to help her cope.

I have to be honest, I am looking for another job. I mean I think I'm... with the year that I've had. I mean my Charge she was actually the one that suggested I cut down to 0.6 (FTE) cos I was getting quite stressed running around after Mum and Dad and having quite a few sick days. (Yvonne)

While Yvonne had clearly shared what was happening outside of work with her employer, for others, like Amy, there was a clear division between what was happening at work and at home, which appeared to come at an emotional cost to her.

I've always been very careful about keeping my home life separate from my work life, my entire work life. My previous Charge Nurse

knew that. I would talk to her and say well I refuse to take my work home with me in any way, shape or form, ... and I think that's had a positive impact on my work life and work relationships. I don't talk about anything that's happening in my family at work but I also don't bring work home. I have very, very clear lines. There are times when it can be quite emotionally draining and then I have to go to work. You know switch off to home and that emotionally draining teenager/young adult kind of drama and they're females so all that goes along with that and then trying to find the energy to put into the workplace mentally, emotionally, physically and spiritually because of course those facets are all really important to us personally and professionally. (Amy)

Outlining the difficulties of maintaining the duality of work and home, many of the women, similar to Yvonne and Amy above, noted increased sick leave and the emotional stress of moving between the personal and the professional. The impact on work outcomes of such conflict has been shown to include negative work attitudes (Buffardi et al., 1999); increased absenteeism and stress in comparison to colleagues without dual responsibilities (Neal et al., 1993) and an increased likelihood of women missing work in comparison to men (Fernandaz, 1990). In support of this Hammer and Neal (2008) argued that women experience more detrimental effects than men because they share a disproportionate amount of the caregiving workload for both ageing parents and children. This can in part be explained with reference to Hochschild and Machung's (1989) "second shift".

The second shift

Thirty years since the concept was first described, an attempt was made to identify how much time women spent on the "second shift" now. As mentioned earlier, the term "second shift" refers to Hochschild and Machung's findings that working women undertook more work than men (quantified as a full month's extra work) because they performed a "second shift", defined as the

unpaid work of looking after their home and/or family, when they came home from their paid work (Hochschild & Machung, 1989). Men were not sharing in these tasks and Hochschild and Machung (2003) attributed this in part to the value placed on what is perceived as women's work.

“... women end up doing the second shift when the second shift is secondary. The more important cost to women is not that they work the extra month a year [in comparison to men]; it is that society devalues the work of the home and sees women as inferior because they do devalued work”. (p274)

A recent literature review identified that despite the majority of women now being in the paid workforce, and the gap between the amount of work men and women undertake reducing, women are still principally responsible for undertaking the key household chores aligned with the second shift (Van Gorp, 2013). Noting that the second shift was more noticeable in those dual income households with children, Van Gorp (2013) argued that its continued existence shows an incongruity with the expectations of women in today's society. While tasks associated with the second shift are still undertaken predominantly by women, rather than being shared with men, expectations on working women continue to cause anxiety as they try to be all things to all people.

Hochschild and Machung's (1989, 2003) work centred mostly on the division of household chores. However the reality of the second shift for the women in this study meant they were constantly juggling expectations from others, including children, partners, parents and employers, as well as their own, while at the same time managing the challenges of menopause. In their initial research, Hochschild and Machung (1989) noted that women seemed disproportionately more concerned about the demands of both family and work in comparison to their husbands. Describing why this may be, Hochschild and Machung (1989) noted that the women appeared to feel more “responsible” for their home and children (p8). They worried about the details (doctors appointments, playdates, child care, parenting ability), Hochschild

and Machung dubbing them the “time and motion expert” of family life (p10). This appears to have resonated with my interviewees, despite other family members being more than capable of organising as well.

Recognising that it was not just their parents who were ageing, there was an awareness among the participants of the importance of looking after themselves too as they moved through menopause. The motivation for this appeared to not only be for their own self-preservation, but so they could continue to take responsibility for doing things for other people. With ageing parents, often the first pressure on the adult child (especially if the adult child is female) is simply a requirement to spend more time, assisting with shopping, household tasks and with medical appointments (Burke & Calvano, 2017). However, being a nurse also meant there were additional expectations from family to provide advice and support, a role the women appeared happy to undertake.

...for menopause I wasn't really keeping well. It was {a kinesiologist's} theory of keeping up to optimum health and looking after yourself, your anxiety. So all of that's kind of important to me so that I can function for not just work but for supporting my family. You know my children and my parents, being a nurse too they ... for my father, he has quite heavy nursing needs ... he's got lots wrong with him. Sometimes he'll wait for a few days while I'm away, but then 10 days after I get home something else will happen and it's important to me to look after myself so I have the strength to look after other people, be there for other people.
(Karen)

The expectation that it is women who will provide care and support to their family members, whether they be ageing parent, dependent child or partner, is referred to as a gendered division of care (Aronson, 1992; Brody, 2003). Often women caring for their ageing parents can be ambivalent about wanting to provide the care, while at the same time wanting to limit how much they do

and prioritise others or themselves without feeling guilty about it (Aronson, 1992). This conflict was apparent in several of this study's participants, particularly in relation to feeling guilty about the choices they made. For Isla, the desire to cope with everything without seeking support saw her dealing with a number of challenges and not wanting to ask other family members to help. Isla described how difficult it had been dealing with an injured husband struggling with depression who was occasionally in hospital, organising childcare, doing the housework and then moving back to New Zealand where her older parents lived. She did not tell her family how challenging it had been for her until she had moved home, adding to the overall stress of her situation. This was the reality of the second shift.

My daughter, she was being dropped off for 7.30 in the morning. I was getting up at 6.30 and dropping her off and (husband) would sometimes be in hospital, and I'd maybe pick her up at 5 o'clock and we'd go and visit Dad in the hospital for a wee bit and we weren't getting home till 6 and then I'd feed her, do the housework and do all that. And to do all of that without family back up, without anything, I did it all on my own. And I didn't let my family know what I was doing either. It was one of those, you know, it's not being too proud, it was with him having depression and everything, people didn't need to know your business. (Isla)

Several of the women in this study mentioned their partners although they said little about their contribution to family life (nor were they specifically asked to). As such no assumptions can be made as to how they may contribute to the commitments described by the women. Despite this it did appear that these women were the main ones who continued to organise children (whether dependent or not) and assisted parents (and in-laws) as required. Calling it the "communal circle of informal help", Hochschild and Machung (2003) recognised this tendency among women to undertake tasks informally (p289). Hochschild and Machung's description also extended to those

undertaking informal assistance within their community (but outside their immediate family), something that was not explored in this study.

Empty nests and boomerangs

Sergeant and Rizq (2017) note that for many menopausal women “available narratives prioritise care of family” (p10). For women whose identity is strongly aligned with their role as a mother, the time when their children leave home can elicit a range of emotions, including sadness, a sense of freedom, relief and guilt (Raup & Myers, 1989). The “empty nest” analogy is one that has commonly been used when talking about mid-life women who are adjusting to their children leaving home. Some women welcome the resultant extra time and freedom that comes with having raised their children to adulthood (George, 2002; Hvas, 2001). Only one participant in this study (Beth) used the phrase “empty nest” directly but others talked of the impact children leaving home had. A more recent review of the literature on the psychological aspects of midlife led Dare (2011) to observe that the focus remained on the need for women to adjust in relation to the “normative model of women as mothers” (p4). Regardless of whether women see themselves primarily as mothers, the impact of children leaving home (positive or negative) is one further change they must adjust to in midlife.

I don't necessarily think it opens a can of worms but there are things like when your kids leave home, some people can't wait for them to move out. (Isla)

This is particularly so for women like Beth, where the leaving was a staged process occurring over several years, thereby prolonging the change.

We're at that empty nesting kind of stage. So over the last four, four and half years two of our three children have left home. And we're left with one at home now and that has an emotional impact. And they haven't just left home to go to local university. One of them left

and went straight to university overseas the day after she turned 18 and the other's in Canada, so it's ... they've well and truly flown the coop. (Beth)

Children moving back home was proving a challenge for others. “Boomeranging”, when adult children move back into the family home, necessitates a readjustment for everyone (Burn & Szoeki, 2016. p9). This changed dynamic sees a need to renegotiate house rules among adults, rather than within a parent/dependent child relationship. A number of studies have identified key areas of friction, including a reticence to contribute financially to the household, not contributing to household chores, and the change in roles that living together as adults necessitates (Burn & Szoeki, 2016; Mitchell, 1998; Aquilino & Supple, 1991).

Although Mitchell (1998) identified several positives when adult children returned home (improved relationships, receiving additional assistance in the home and having the family back together), when moving back in with their parents they were often returning to a household that had grown accustomed to their absence. The resultant loss of privacy and ability to do whatever they want in their own home can also have a demoralising effect on parents (Mitchell, 1998). Interestingly Mitchell (1998) noted that how well the living situation with the “boomerang kid” at home was progressing impacted on parental wellbeing (p40), and in some cases exaggerated existing difficulties or family relationships already under strain. This was particularly so for women who are the ones who usually pick up the extra tasks involved when an adult child moves home. This signals another example of a return to the “second shift” as women cover the work not provided for in the paid labour market (Mitchell, 1998; Hochschild & Machung, 1989). Difficulties in readjusting to the changed roles can be a fraught process as Carrie describes.

My son's moved back home with his partner, for 10 months, while their house is being built. It's ... that's stressful. And it's learning to cope all over again. The triggers and things, because he thinks he's

being funny but he's just being an arsehole. Yeah ... I'm the adult, and I have life skills that pull in, plus I've got his girlfriend (onside).
(Carrie)

Sometimes this conflict can arise where the child has not progressed to a more adult lifestyle, for example in full-time work, able to contribute to household tasks and a willingness to fit in with the parental home (Burn & Szoeki, 2016). Sometimes these changes were happening simultaneously with more than one child, as they were for Yvonne whose son was leaving and her daughter moving back in.

Yeah and your children, my son's about to graduate from police college. So I'm organising all his stuff because he missed his flight down and then his girlfriend is saying I want this and not this and I'm like well he's going ... and then my daughter's just moved back home because her relationship has just broken up. (Yvonne)

Despite the added stress their children moving either out or back into their home brought to them, none of the women in this study spoke of not wanting this to happen. When talking of what was occurring they were all matter-of-fact about things, although several did reflect on the extra work this was making for them. Burn & Szoeki (2016) found that adult children moving back with their parents tended to have increased expectations, particularly of mothers, and sometimes saw them as “being there to cater to their needs” (p10). However mothers must still be prepared to accept and then act on those expectations. When Yvonne spoke of how she was sorting her sons’ belongings because he had missed his flight, it was unclear whether he had asked her to do this or whether she was taking this responsibility on herself. Her decision to step in and resolve what could be argued was her son’s issue was consistent with her being the one in her family who sorts things out. With her son leaving, a daughter returning home to live, an elderly father that she was sorting finances for as well as undertaking shift work, Yvonne was an extremely busy woman. Unsurprisingly she had recently reduced her hours of work and had

been experiencing anxiety. Like her, all of the women who I interviewed were busy, with multiple commitments. This fits with Miller's findings (Miller, 1981) that "the sandwich generation will carry disproportionate responsibilities" as the norm (p420).

Sometimes it is not until a stressful situation is over that recognition is given to just how difficult it has been and what the true impact on someone was. Finding herself tearful and experiencing exacerbated menopausal symptoms several months after supporting her daughter through a depressive event, Eve finally acknowledged to herself how traumatic her experience was.

Um I had some real issues with my daughter. I had her in a depressive episode and she took some pills and I was beside myself with worry, and I personally think that triggered the hot flush time. I sort of think the stress ... I don't know why, I couldn't tell you. It was quite interesting, it wasn't actually at the time the event occurred. I had to deal with that at the time but I just sort of felt like four months later I just found myself really tearful and crying all the time and I realised I hadn't, I was so busy being strong that I realised I hadn't acknowledged how devastated I was by what happened. I thought she was a strong robust independent person, and she still is at times ... I was really low and I ended up having a few days and had bad menopausal symptoms and I wondered if that had, was associated with that. I don't know whether it was. Whether one triggered the other or was because of the other. (Eve)

Like Eve, the participants in this study often talked of situations where they put others first. Whether it was allowing their adult children to move back home, assisting their ageing parents or putting their partner's needs ahead of their own, the women were at a time in their lives where they were not the main priority. Despite this many of the women were anticipating being able to concentrate more on themselves, though often this would still be in between their other commitments.

Re-evaluating identity – an opportunity to review

Women in mid-life often reach a point where they realise their experiences of menopause, while having an impact on them now, would not last forever. Teresa referred to menopause as being both “a line in the sand” and “a point of no return” and this sense of being in the present, able to look back but only move forward, was a common theme in my interviews. With children becoming less dependent (albeit possibly still living at home) many of the women I interviewed were also starting, on several levels, to re-evaluate their lives. Making the transition from a family unit, where as a mother they had a busy and clearly defined role, to a more separate sense of who they were, necessitated a reassessment of many aspects of their lives. Who they were as an individual is something that often gets lost in the mothering years, both by them as women and also by society, and they appeared to be in a state of transition towards an often uncertain next stage of life.

Gordon et al. (2002) described this as a “recalibration” by women in mid-life, observing an increased cognizance of their many roles and the interplay between them, and noting a reassessment and change that followed this (p336). This is similar to Sergeant & Rizq’s (2017) observation in relation to women taking an “opportunity to review ... a return to focus to their own development” especially as they moved to an increasing focus away from family responsibilities (p10). Similarly Howell & Beth (2002) described this phase as “adjusting attitudes, behaviors, and circumstances” as women come to terms with who they are (or will be) as they move through mid-life. Part of the adjustment in this study was the recognition that their child-bearing years were behind them, and this appeared cause for both reflection and sadness among the women. Often it was not that there was a desire for more children, it was more the implications for them as a woman who was no longer young enough to have children.

It's the end of the reproductive phase of your life. I mean for some people it's like hallelujah I don't have to have a period again. For

other people it's not quite so simple, but you know, I just think it's that moving into the next phase of development really. You're no longer reproducing or reproductive age anymore, that's probably the simplest way to describe it really. (Beth)

... it was weird, I guess I thought aww, I'm not fertile anymore which is ridiculous because there is no way I would want any more children... I guess in terms of if you ever thought you weren't that old well you are actually ageing, you know you can't call yourself young in any shape or form, you're definitely middle-aged, or older. (Teresa)

Feeling uncertain and confused during menopause has been linked to socially driven ageist and sexist views of mid-life women, particularly when the dominant discourse for mid-life women devalues their worth (Chrisler, 2013; Rubenstein & Foster, 2012; Bannister, 2000). Similarly Sergeant & Rizq (2017) found women perceived being an "older woman" with "dismissive social narratives, questioning their health, relevance and vigour" challenging (p196). Mid-life women as a group are essentially marginalised in a culture which promotes youth, often resulting in a questioning of self-esteem and a struggle to understand how they feel about being situated within that demographic (Strauss, 2011; Howell & Beth, 2002; Banister, 2000).

Many of the women I interviewed mentioned how surprised they were to find themselves at this stage of life. Teresa outlined this succinctly above, and like her the others acknowledged that there does come a point of acceptance that mid-life has definitely arrived, although not everyone was happy about that. The disconnect between what they felt internally and what they saw in the mirror appeared to cause confusion and a sense of disappointment for some. Howell & Beth, (2002) found a similar disconnect however in their study the participants had differentiated between "being" and "feeling" middle-aged (p193). They reserved their more negative comments for other middle-aged women in general, using more positive concepts to describe both themselves

and fellow group interviewees. The participants in Howell & Beth's (2002) study acknowledged the stereotypical nature of the labels they had associated with those mid-life women, at the same time indicating that they did not apply to them, despite accepting their ages and conceding that mid-life was bringing change. In contrast, for some of the women in this study, like Leyla, this acceptance of mid-life was embraced with enthusiasm and positivity. Leyla had experienced a difficult time throughout menopause and she attributed her more recent positive outlook to a book she had read (Norgate, 2012) which she described as having helped her to understand herself and have a more positive outlook. She returned to the book a number of times throughout the interview, recommending it to all women going through menopause, saying it should be "required reading".

Whether you want it or not you've got it. So you've got to make the most of it, and when I say the most of it, it's the most incredible thing. It gives you the opportunity ... you're re-evaluating yourself, who you want to be as a person. You know, do I want to be doing this job for the rest of my life? Am I happy where I am right now? What can I do that's different? All of those things ... you're knocking on another door, a huge big door that you've never knocked on before and you're not so worried about what people think anymore. Hopefully this is the place in your life where you can actually go off on your horse carrying a flag (laughs). (Leyla)

Leyla recognised that not everyone was feeling positive about menopause, acknowledging it was "... more of a progression cos I've been in that (not positive) space too". Sergeant & Rizq (2017) found many women were feeling apprehensive and uncertain as they grappled with just who their menopausal self was, and how that fitted with a shift in their focus to new aspirations. As a result women often begin to make changes in their lives, and this was starting to occur for several of the women I interviewed.

The theme of change is a constant throughout any discussion of menopause, and as noted in Chapter Four, previous generations of women often referred to it by that name (“the change”). This sense of transformation has also been called “a new life phase” (George, 2002, p83); allowing for the “possibility of personal inner growth” (Hvas, 2001, p16); “understanding the personal relevance of those changes” (Howell & Beth, 2002, p195) while at the same time being a “multi-faceted process” (Newhart, 2013, p373). Changing jobs both within and outside of their organisation, reducing hours or leaving work completely were all options being considered by the women I interviewed. The reasons for this were varied (a move away from shift work, new opportunities, nicer work environment), and may also have been exacerbated by the fact the interviews mostly took place at the end of the year, a time for many to consider change anyway.

Yeah it's been a huge year, I'm really looking forward to the next one. And that is why I think it might be a good time to move (jobs) as well, new beginnings. (Yvonne)

For those with partners it was also a time to reconnect and begin to make plans for the future. Although seen as a positive thing for these women, sometimes this can have the opposite effect. It can force some couples to address relationship issues put to one side during the child-rearing years. Rates of divorce during mid-life are high and can disproportionately impact on a woman's financial situation and her social support network, (Dare, 2011).

So it's hard, a change of dynamic, having more time for me. Which is really weird. It's like a change of dynamic in your relationship because suddenly you and your partner have more time for each other and talking about retirement. Like I'm only 50 and my husband's a little bit older than me, but we have plans, stuff we want to do in the next five, six, seven years. Which means we're going to be completely turning our lifestyle on its head. So all that stuff's going on as well. So how much of the tiredness, exhaustion is

related to those changes and probably the whole factorial thing of them all being thrown in together. (Beth)

Despite the women in this study leading busy lives, with the responsibility of mothering becoming less hands-on, some women found they had more time available outside of work, time they could choose to use as they wanted. For several of the women this concept of having spare time was still unique and they often appeared unsure of what to do with it. Talking about a fitness initiative at work that encouraged people to go out and exercise with their colleagues, Beth commented on how it was providing something to help her fill that gap.

...but something happens and people become interested in each other outside the workplace as well. It takes a bit of a burden off so if you're going through crap or if you're like, I've just had the worst run of luck over the last few months with different things going on but I feel like they've got my back. And I feel like if it's really hard I can go, look I'm not coping, and they'll go right what can we do? It gives me something to do at a time when you do have more time. It's like do I sit at home and feel sorry for myself or do I go and hit a punching bag with a couple of work mates. This initiative could have a really positive impact on women my age, you feel tired and you feel like crap but you go out and have a laugh. There's no judging, everyone supports each other through and that's had a huge impact. (Beth)

The idea of generativity comes from the psychosocial theories of development of Erik Erikson (1963; 1982). Generativity can be described as “...the concern to nurture, guide and ensure the well-being of future generations...” (Villar, 2012, p1094). Although it could be argued that this is what women do anyway when they are mothering, Villar (2012) described a broader scope of activity which also included caring for others, the education and mentoring of those younger than themselves, providing services, and involvement in community

and political activities. He saw generativity as “contributing to the maintenance and enhancement of the contexts in which the individual participates (families, communities, companies, etc.)” (Villar, 2012, p1095). At mid-life this desire to give back is often a result of women feeling more confident in themselves as they move through their menopause transition, leading to women having a formidable influence in their relationships with others (Degges-White, 2001).

One of the last questions I asked each of the women in this study was about what advice they would share with other women who were menopausal. Their responses ranged from the practical (drink more water, less alcohol and hot drinks, take supplements and exercise) to the educational (read, talk and research more about menopause; learn what’s happening in your own body). A key theme was look after yourself and tell someone if you are struggling, “... then they’ve got your back” (Eve). Although not mentioned explicitly, the choice of who to tell was linked directly to issues of trust as the act of confiding in itself does not ensure support. Amy describes below how taking on this role is something she enjoys.

There’s a number of younger staff who feel comfortable enough to confide in me and know it won’t go any further. The walls at work hold a lot of ‘gossip’, though I shouldn’t call it that. I’m happy to be a listening ear rather than give advice, sometimes putting a different spin on things or a different perspective. I kind of welcome it though it’s good for my ego that they think they can do that and I’d like to think that they can.’ (Amy)

Similary Isla was confident in both her role in helping her daughter improve how she communicated as well as identifying when her work colleagues needed some support.

I'm the one my daughter wants to talk to, she comes to me. She can't talk to her Dad, he doesn't understand her and that's part of her learning. So it's trying to help her evolve as a person, and teach her how you can communicate with people. You've got to learn how you can talk about relationships, talk about anything. It doesn't matter whether they're still at home. I think I'm very observant with people, so I pick up different things with people, but it's because it's what I do and I know what I do. And so with your work colleagues, as much as people try not to bring things that are happening outside of work into work, if things are happening then I'll take them aside, and say do we need to have a chat because it seems to me that you're doing da da da ...? (Isla)

Initially many of the women were unsure what thoughts about menopause, and their lived experience of it, they had that would be worth sharing. When they thought about it though every woman had something to share, and many commented they would have liked to have had someone to impart their menopause wisdom to them earlier in their journey.

Summary

This chapter has explored the other roles and responsibilities the participants were undertaking alongside working as a nurse, set against the backdrop of menopause. It has revealed the many complex relationships that mid-life women have with their immediate and extended families. Highlighting how Hochschild and Machung's (2003) "second shift" remains applicable to this group of women, I have also considered its broader application to ageing parents and dependent (sometimes "boomeranging") children (Mitchell, 1998). Although strength and resilience was obvious among this cohort, these extra stresses outside of work, and on top of menopause, challenged their capacity to cope. As noted in Mackin (1995) "...women's midlife experiences are especially linked to the choices and contingencies of other family members ... Women's responsibilities and options shift accordingly" (para 16). This

chapter concluded with a consideration of how this group of women were beginning to re-examine their identity in readiness for the next stage of their life, post-menopause. The following chapter will discuss the key findings of this study and look at the implications of these for nurses who are working through menopause and their employers.

Chapter Seven - Discussion and Conclusion

As women's participation in the workforce has grown, so too has the number of women who are experiencing menopause at their place of work. Despite this, menopause remains stigmatised (Duffy et al., 2011), associated with negative connotations of ageing (Ussher, 2008) and largely remains hidden within the workplace (Morris & Symonds, 2004; Kittell et al., 1998). This research focused on how women constructed their understanding of menopause – both within their workplace and the social context within which they live. Describing the physical and emotional challenges they were facing, and how they made sense of these, the women in this study provided an insight into the lived experience of menopause for nurses working at a tertiary hospital in New Zealand. This chapter will consider the implications and key findings of this study. It focuses on how women struggle with the visible signs of menopause within the workplace, both at a personal level and in relation to their work colleagues and shows the importance of understanding this within the context of women's lives. Suggestions for future research are also considered.

Having and being a menopausal body at work

It is largely the biomedical discourses of menopause that have shaped, and continue to shape, how women construct their understanding of it. This has been achieved by describing menopause in terms of physiological symptoms (for example hot flushes and night sweats), offering blood tests to verify menopausal status and offering medical management for something which may be progressing routinely. As with pregnancy and childbirth, the default for addressing menopause has been similarly medicalised (De Lyser & Shaw, 2013; Rubenstein, 2014; Morris & Symonds, 2004), often resulting in uncertainty about what a normal healthy experience of menopause would be (Mackey, 2007; Marnocha et al., 2011).

The medical profession remains a key influencer on women's decision making in relation to menopause (George, 2002; Morris & Symonds, 2004), and this was also true for the participants in this study. Many of the women were experiencing bodily changes which they were uncertain about in terms of cause or meaning. Although they suspected early menopause, it appeared important to have this confirmed by a medical professional, while many also sought clarification from friends or female family members. Marnocha et al. (2011) argues that women seek information rather than reflect acceptance of the "medicalised model of care" (p238). This confusion as to whether they are or are not menopausal appears as a common theme in menopause literature, with women unsure of what to expect and concerned as to whether what they are experiencing is "normal" (Marnocha et al., 2011; George, 2002; Sergeant & Rizq, 2017; Mackey, 2007).

Women's lived experiences may differ from the medical model (Morris & Symonds, 2004) and making sense of medicalised versus non-medicalised approaches to menopause can result in conflict. Ussher (2008) argued that being able to describe an embodied change does not necessarily mean it is of concern. However, like the women in Marnocha et al.'s (2011) study, some women in this study received prescriptions and antidepressants rather than reassurance or further discussion about what they were experiencing. Similarly, Goldstein (2000) noted that the emphasis on menopause as "unproblematic" silences those for whom it most definitely is not (p320). Underlying this discord, the biggest challenge facing the women in this study was how to manage the visible displays of menopause in the workplace.

In a society that values youth, women become largely invisible as they age, with menopause and ageing closely linked for many women. In this study, several participants commented that they did not see themselves as old enough to be menopausal, with others hoping they looked younger so as to avoid colleagues perceiving them to be that old. Despite this, the women in this study were not as fixated on ageing itself as some of the other studies linking menopause and ageing have indicated (Stephens, 2001; Utz, 2011; Ussher,

2008). Rather, the concern related to maintaining control of their bodies in a workplace that was not always conducive to the challenges faced by many menopausal women.

With little conversation in the workplace around menopause and the negative connotations mentioned above, many women are still reluctant to disclose their menopausal status at work. Women in this study gravitated to others at a similar life stage and were happy to share their experiences with them, but hesitant to be open with younger or male colleagues. When visible bodily displays (such as a hot flush) occurred in front of others it was the sense of losing control over their body that women struggled with. The outcome of using humour to help address the resultant discomfort felt by both the women and those observing them was variable. The “perceived social etiquette of keeping menopause hidden” sees women continuing to silently manage their recalcitrant body at work (Sergeant & Rizq, 2017 p197).

The importance of context

For the group of women in this study, context was extremely important in the construction of their menopausal experiences, although this was not always immediately obvious. Stephens (2001) described a moral aspect among the women in her study who were feeling well during menopause, asserting that by focussing on things other than what was happening with their body the women felt they were in some way “morally virtuous”. Similarly, Stephens & Breheny (2008) described menopausal women justifying their choices as either taking “care of the(ir) body” or “getting on with it” regardless (p16). Although women in the current study spoke of mitigating some of their bodily changes by making an effort to “take care of” their body, the majority appeared to approach menopause as one more thing to deal with in an already crowded life. Many appeared to feel they had no other choice but to “get on with it”. While also managing their own menopausal journey, all of the women who were interviewed had experienced or were experiencing, a range of stressful life transitions.

In contrast to Mackey (2007), who found that having multiple other changes in their lives meant women focussed on those changes rather than on menopause, the women in this study reported that their symptoms worsened when stressful situations occurred alongside them. Caught between their ageing parents and their own maturing children (who may still be at home or still requiring support in some way), working women often carry the extra strain of a “second shift” from outside work (Hochschild & Machung, 2003). The stress from these added responsibilities, alongside menopause, can result in considerable distress. The findings from this study also highlighted the added stress of living in a city still affected by a series of major earthquakes five years earlier. Still sorting earthquake issues in their personal circumstances, at work the women were contending with ongoing building repairs and multiple workplace shifts. The Canterbury DHB has acknowledged the ongoing stress due to these residual earthquake issues on a number of occasions. Further heightening this stress was the occurrence of a 7.8 magnitude earthquake in Kaikoura that occurred in the middle of this study’s interviews.

Staying (a) professional at work

During menopause, women may experience a number of things that can interfere with their ability to undertake their duties at work. For nurses, lack of sleep, tiredness, shift work, anxiety, memory problems and mood swings can all contribute to issues such as medication errors, impaired judgement or communication difficulties with colleagues. As a result, women often find themselves challenged by their experience of menopause to remain in control while maintaining a professional persona at work.

As awareness continues to grow of the possible impact of menopause on work, services are under development to enable women to access support should they need it. The United Kingdom, in particular, is leading the way in terms of identifying menopause as an occupational health issue. Griffiths et al. (2010) referred to menopause as a “major health event” (p13) although this approach

does position menopause as an illness rather than a life stage. The Royal College of Nursing (RCN), also in the United Kingdom, has recently issued guidance for their RCN representatives outlining how employers can help and providing information about possible symptoms, their potential interface with work and suggested adjustments that could be helpful (Royal College of Nursing, 2016). In this document, the RCN outlines its peer support service, set up specifically for nurses experiencing menopause. The service puts members in touch with each other by email, noting that due to the specialised nature and environment of health, speaking with other health care professionals about issues can be particularly helpful.

There is also a growing awareness in New Zealand that those working in health services also need information about menopause. The State Services Commission produce information and resources on menopause and work, linked to general health and wellness, although it draws heavily on the study by Griffiths et al. (2010) mentioned above (State Services Commission, 2016). In 2014 the Canterbury District Health Board (CDHB), as part of its staff well-being programme, ran an information session on menopause, running live feeds via video conference across multiple sites. This event was so well attended that the video recording was put on YouTube and the link made available on the staff Intranet (internal website), so it could continue to be accessed by women at a time and place suitable to them (Canterbury District Health Board, 2014).

Future directions for research

This small qualitative study has explored the lived experience of menopause for a relatively homogeneous group of nurses. As mentioned earlier in the literature review, there is a lack of research on the lived experience of menopause for Māori women, and as this study attracted no Māori participants it makes no contribution either. Lawton et al. (2008) identified differences between Māori and non-Māori women in how they responded to embodied changes during menopause and noted the need for further investigation. The

opportunity for further research to explore how Māori women experience menopause remains.

Although women do see menopause as a natural process, when they are seeking further information or assistance in understanding or addressing what is happening to them, the first place they often go is to their general practitioner. Many of the women in this study consulted clinicians about the changes they were experiencing suspecting they were menopausal, however the responses they received were variable and often not particularly helpful. Future research could explore the attitudes and beliefs of general practitioners in relation to menopause and examine how these may influence what information and treatment options the clinician offers to women.

When I first commenced this research one of the aims was to encourage more open discussion around menopause in the workplace. It has become clear that for this to occur there first needs to be a shift in how comfortable women feel about discussing menopause openly. Future research could explore what the barriers are for this to occur, and could consider whether changes in the workplace would be sufficient or if a change is required in a wider context. The more opportunities women have to share their lived experience of menopause in a safe way, the greater the potential for all women to benefit from this.

Conclusion

This study addresses the gap in the literature around the lived experience of menopause at work for nurses in New Zealand. It also explores the varying influences outside of work that have an impact on that lived experience. Previous research has tended to focus on menopause as a problem, something that requires a solution; however it may be of more use to women to focus on their lived experience rather than perceived difficulties (Mackey, 2007). It is important that more consideration occurs as to how the workplace may be able to accommodate some of the needs of menopausal women working in the health sector. Whether that is through an increased flexibility in expectations

of shift work requirements; enabling women who are having issues with hot flushes, excessive perspiration or heavy bleeding to discreetly attend to their needs; or through providing a place where further information or supportive discussion can occur. As noted earlier the workplace is currently not a welcoming space for the leakiness of women. If mid-life nurses are to be encouraged to continue in their roles it is important that the workplace itself does not become a barrier to doing so.

References

- Abramson, Z. (2007). Masked Symptoms: Mid-life Women, Health, and Work. *Canadian Journal on Aging / La Revue canadienne du vieillissement*, 26, 295-303. doi:10.3138/cja.26.4.295.
- Aquilino, W. S. and Supple, K. R. (1991). Parent-Child Relations and Parent's Satisfaction with Living Arrangements When Adult Children Live at Home. *Journal of Marriage and Family*, 53 (1). (Feb., 1991), 13-27. doi: 10.2307/353130, Stable URL: <http://www.jstor.org/stable/353130>
- Australasian Menopause Society website. Menopause Basics. Accessed March 2016: <http://www.menopause.org.au/health-professionals/management/menopause-basics>
- Aronson, J. (1992). Women's Sense of Responsibility for the Care of Old People: "But Who Else Is Going to Do It?". *Gender & Society*, 6 (1), 8-29.
- Ashforth, B. E., and Humphrey, R. H. (1993). Emotional labor in service roles: The influence of identity. *Academy of Management Review*, 18: 88 -115.
- Bannister, E. M. (2000). Women's midlife confusion: Why am I feeling this way? *Issues in Mental Health Nursing*, 21, 745-764.
- Bauld, R. and Brown, R. F. (2009). Stress, psychological distress, psychosocial factors, menopause symptoms and physical health in women. *Maturitas*, 62 (2), 160-165. <https://doi.org/10.1016/j.maturitas.2008.12.004>
- Bazzin, D. G., McIntosh, W. D., Smith, S.M., Cook, S. and Harris, C. (1997). The Aging Woman in Popular Film: Underrepresented, Unattractive, Unfriendly, and Unintelligent. *Sex Roles*, Vol. 36, Nos. 7/8.
- Beasley, A. N. (1999). Menopause in context: a constructivist/interpretive perspective on the attitudes,

perceptions, expectations and experiences among women in New Zealand. Massey University. Accessed from: <http://mro.massey.ac.nz/handle/10179/2455>

Berger, R. (2013). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research* 0(0) 1-16. doi: 10.1177/1468794112468475

Bochantin, J. (2014). "Long Live the Mensi-Mob": Communicating Support Online With Regards to Experiencing Menopause in the Workplace. *Communication Studies*, 65:3, 260-280. doi: 10.1080/10510974.2013.811433

Boston Women's Health Book Collective. (2011). *Our bodies, Ourselves*. Simon & Schuster, New York.

Boston Women's Health Collective. (1973). *Preface to the 1973 Edition of Our Bodies, Ourselves*. Accessed from: <http://www.ourbodiesourselves.org/history/preface-to-the-1973-edition-of-our-bodies-ourselves/>

Brantelid, I.E., Nilver, H. and Alehagen, S. (2014). Menstruation During a Lifespan: A Qualitative Study of Women's Experiences. *Health Care for Women International*, 35 (6), 600-616. doi: 10.1080/07399332.2013.868465

Braun, V., and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.

British Menopause Society (2015). NEWS: Chief Medical Officer calls for workplaces to be more menopause friendly. Retrieved from <https://thebms.org.uk/2015/12/chief-medical-officer-calls-for-workplaces-to-be-more-menopause-friendly/>

British Menopause Society, 2013. Summary consensus statement - Hormone replacement therapy: Managing the Menopause. Accessed from: <https://thebms.org.uk/clinical-statements/consensus-statements/hormone-replacement-therapy/>

- Brody, E. M. (2003). *Women in the middle: their parent-care years* – Elaine M. Brody, with contributions by Avalie R. Saperstein. – 2nd ed. Springer Publishing, New York.
- Brooks, A. and Hesse-Biber, S. N. (2006). An invitation to feminist research. In Hesse-Bieber, S.N. and Leavy, P. L. (Eds), *Feminist Research Practice: A Primer*. (pp 1-24). California, Sage Publications.
- Broughton, C. (2016). Quakes cause heart problems and mental stress. Accessed from: <http://www.stuff.co.nz/national/health/86484596/quakes-cause-heart-problems-and-mental-stress>
- Bryant, C., Judd, F. K. and Hickey, M. (2012). Anxiety during the menopausal transition: A systematic review. *Journal of Affective Disorders*, 139 (2012), 121-148. doi:10.1016/j.jad.2011.06.055
- Buffardi, L. C., Smith, J. L., O'Brien, A. S., & Erdwins, C. J. (1999). The impact of dependent-care responsibility and gender on work attitudes. *Journal of Occupational Health Psychology*, 4, 356 –367.
- Burke, R. J., & Calvano, L. M. (Eds.). (2017). *The Sandwich Generation: Caring for Oneself and Others at Home and at Work*. Cheltenham, UK: Edward Elgar Publishing. <https://doi-org.cmeziproxy.chmeds.ac.nz/10.4337/9781785364969>
- Burn, K., & Szoek, C. (2016). Boomerang families and failure-to-launch: Commentary on adult children living at home. *Maturitas*, 83, 9-12.
- Calás, M. B. and Smircich, L. (1999). Past Postmodernism? Reflections and Tentative Directions. *The Academy of Management Review*, 24 (4), 649-671. Stable URL: <http://www.jstor.org.cmeziproxy.chmeds.ac.nz/stable/259347>
- Canterbury District Health Board, 2014. CDHB Staff Wellbeing Programme - Managing Menopause 2014 (Video file). Accessed from: <https://www.youtube.com/watch?v=UkDAA-5IV6c>

- Chadha, N., Chadha, V., Ross, S., and Sydora, B. (2016). Experience of menopause in Aboriginal women: A systematic review. *Climacteric*, 19(1), 17-26.
- Chrisler, J. C. (2011). Leaks, lumps, and lines: Stigma and women's bodies. *Psychology of Women Quarterly*, 35, 202–214. doi:10.1177/0361684310397698
- Clark, S. H. and Schwiebert, V. L. (2001). Penelope's Loom: A Metaphor of Women's Development at Midlife. *Journal of Humanistic Counseling, Education and Development*, 40 (2), 161(10).
- Clendon, J. and Walker, L. (2013). Nurses aged over 50 years and their experiences of shift work. *Journal of Nursing Management*, 2013, 21, 903-913.
- Coney, S. (1994). The menopause industry: How the medical establishment exploits women. Alameda, CA: Hunter House.
- Crawford, M. (1989). Humor in conversational context: beyond biases in the study of gender and humor. In: *Unger, R.K. (Ed.), Representations: Social Constructions of Gender*. Baywood Publishing, Amityville, New York, 155– 166.
- Dare, J. S., (2011). Transitions in midlife women's lives: Contemporary experiences. *Health Care for Women International*, 32(2), 111-133.
- Davies, S.C. (2015). "Annual Report of the Chief Medical Officer, 2014, The Health of the 51%: Women". London: Department of Health.
- Degges-White, S. (2001), Midlife Transitions in Women: Cultural and Individual Factors. *Adultspan Journal*, 3: 4-11. doi:10.1002/j.2161-0029.2001.tb00100.x
- De Lyser, D. and Shaw, W.S. (2013). For menopause geographies. *Area*, 45 (4), 504-506, 2013. Accessed from: <http://onlinelibrary.wiley.com/doi/10.1111/area.12059/full>

Dictionary.com, online dictionary. Accessed June 2016:

<http://www.dictionary.com>

Dillaway, H. E. (2011). Menopausal and Misbehaving: When Women 'Flash' in Front of Others. *In book: Embodied Resistance: Breaking the Rules in Public Spaces, Edition: 1, Chapter: 15*, Publisher: Vanderbilt University Press, Editors: Chris Bobel and Samantha Kwan, 197-208. Accessed from: https://www.researchgate.net/profile/Heather_Dillaway/publications

Dillaway, H. E. (2005). (Un)Changing Menopausal Bodies: How Women Think and Act in the Face of a Reproductive Transition and Gendered Beauty Ideals. *Sex Roles*, 53 (1/2), 1-17. doi: 10.1007/s11199-005-4269-6

Dobson, S. (2016). Employers encouraged to break through stigma of menopause. *Canadian HR Report*; Feb 22, 2016; 29 (3). ProQuest Central p8.

Drake, P. (2010). Grasping at methodological understanding: a cautionary tale from insider research. *International Journal of Research & Method in Education*, 313:1, 85-99. doi: 10.1080/17437271003597592

Duffy, O.; Iversen, L. and Hannaford, P.C. (2011). The menopause "It's somewhere between a taboo and a joke". A focus group study. *Climacteric* 2011; 14:497:497-505.

Dworkin, S.L. (2012). Sample Size Policy for Qualitative Studies Using In-Depth Interviews. *Archives of Sexual Behavior*, December 2012, 41 (6), 1319-1320. doi: 10.1007/s10508-012-0016-6

Erikson, E. H. (1963). *Childhood and society*. New York: Norton.

Erikson, E. H. (1982). *The life cycle completed*. New York: Norton.

Fenton, A., and Panay, N. (2013). Menopause - quantifying the cost of symptoms. *Climacteric*, 16(4), 405-406. doi:10.3109/13697137.2013.809643

- Fernandez, J. P. (1990). The politics and reality of family care in corporate America. Lexington, MA: *Lexington Books*.
- Gabrielle, S., Jackson, D. and Mannix, J. (2008). Older women nurses: health, ageing concerns and self-care strategies. *Journal of Advanced Nursing* 61(3), 316-325. doi: 10.1111/j.1365-2648.2007.04530.x
- Galletta, A., and Cross, W. E. (2013). Mastering the Semi-Structured Interview and Beyond: From Research Design to Analysis and Publication. Retrieved from <http://www.ebilib.com>
- Genuis, S. (2012). Constructing 'sense' from evolving health information: A qualitative investigation of information seeking and sense making across sources. *Journal of the American Society for Information Science & Technology*, 63(8), 1553-1566. doi: 10.1002/asi.22691
- George SA. (2002). The menopause experience: A woman's perspective. *Journal of Obstetrics, Gynecologic and Neonatal Nursing* 31, 77-85.
- Goffman, E. (1990). The Presentation of Self in Everyday Life. London, England: *Penguin Books*.
- Goffman, E. (1959). The Presentation of Self in Everyday Life. New York: *Anchor Books*.
- Goldstein, D. E. (2000). When ovaries retire: contrasting women's experiences with feminist and medical models of menopause. *Health*, 2000, 4 (3), 309-323.
- Gordon, J. R., Beatty, J.E. and Whelan-Berry, K. S. (2002). The Midlife Transition of Professional Women with Children. *Women in Management Review* 17(7), 328-341.
- Gracez, T. (2003). Older women's experiences of menopause: A feminist descriptive study of older women's knowledge and attitudes toward menopause. *Massey University*. Accessed from: <http://hdl.handle.net/10179/7113>

Gray B. (2012). Emotions and Nursing. In: *Face to Face with Emotions in Health and Social Care*. Springer, New York, NY.

Gray, B. (2009). The emotional labour of nursing – Defining and managing emotions in nursing work. *Nurse Education Today*, 29 (2), 168-175.

Green, J. and Thorogood, N. (2014). *Qualitative Methods for Health Research* 3rd Edition. London: Sage Publications Ltd.

Greer, G. (1991). *The Change: Women, Ageing and the Menopause*. Hamish Hamilton, 1991.

Griffiths, A., MacLennan, S.J. and Hassard, J. (2013). Menopause and work: An electronic survey of employees' attitudes in the UK. *Maturitas* 76 (2013) 155-159. doi: 10.106/j.maturitas.2013.07.005

Griffiths, A., MacLennan, S. and Wong, Y.Y.V. (2010). Women's Experience of working through the Menopause. *Institute of Work, Health & Organisations*. Accessed June 2016 from: http://www.bohrf.org.uk/downloads/Womens_Experience_of_Working_through_the_Menopause-Dec_2010.pdf

Guay, M. P., Dragomir, A., Pilon, D., Moride, Y. and Perreault, S. (2007). Changes in pattern of use, clinical characteristics and persistence rate of hormone replacement therapy among postmenopausal women after the WHI publication. *Pharmacoepidemiology and Drug Safety*, January 2007, 16(1), 17-27.

Guest, G., Bunce, A., and Johnson, L. (2006). How Many Interviews Are Enough? An Experiment with Data Saturation and Variability. *Field Methods*, 18(1), 59-82.

Guadagno, R.E. and Cialdini, R.B (2007). Gender Differences in Impression Management in Organizations: A Qualitative Review. *Sex Roles*, 56, 483– 494.

- Hammam, R.A.M., Abbas, R.A. and Hunter, M.S. (2012). Menopause and work – The experience of middle-aged female teaching staff in an Egyptian governmental faculty of medicine. *Maturitas* 71 (2012) 294-300. doi: 10.1016/j.maturitas.2011.12.012
- Hammer, L. B. and Neal, M. B. (2008). Working sandwiched-generation caregivers: Prevalence, characteristics, and outcomes. *The Psychologist-Manager Journal*, 11(1), 93-112.
<http://dx.doi.org/10.1080/10887150801967324>
- Hartman, A. (1990). Many ways of knowing [editorial]. *Social Work*, 35 (1), 3-4. Accessed from: http://www.psyking.net/HTMLobj-3801/Many_Ways_of_Knowing.pdf
- Hinchliff, S., Gott, M., and Ingleton, C. (2010). Sex, menopause and social context: A qualitative study with heterosexual women. *Health Psychology*, 15, 724.
- Hirshkowitz, M. et al. (2015). National Sleep Foundation's sleep time duration recommendations: methodology and results summary. *Sleep Health*, 1 (1), 40-43.
<https://doi.org/10.1016/j.sleh.2014.12.010>
- Hochschild, A. R. and Machung, A. (2003). The second shift. New York: Penguin Books.
- Hochschild, A., & Machung, A. (1989). The second shift: Working parents and the revolution at home. New York: Viking.
- Hochschild, A. R. (1983). The Managed Heart – Commercialisation of Human Feeling. *University of California Press*, Berkeley and Los Angeles, California.
- Hochschild, A.R. (1979). Emotion Work, Feeling Rules, and Social Structure. *American Journal of Sociology*, 85 (3), 551-575
- Hoga, L.A.K.; Rodolpho, J. R.C.; Goncalves, B.G. and Quirino, B. (2014). Women's experiences of menopause: a systematic review protocol of qualitative evidence. *The JBI Database of Systematic Reviews and Implementation Reports*, 12 (7).

- Holmes, J. (2006). Sharing a laugh: Pragmatic aspects of humor and gender in the workplace. *Journal of Pragmatics*, 38 (2006), 26-50.
- Houck, J. A. A. (2003). "What Do These Women Want?" Feminist Responses to Feminine Forever, 1963-1980. *Bulletin of the History of Medicine* 77 (1), 103-132. Accessed from: [http://homepage.ntu.edu.tw/~psc/20040606 WHAT%20DO%20THESE%20WOMEN%20WANT.pdf](http://homepage.ntu.edu.tw/~psc/20040606%20WHAT%20DO%20THESE%20WOMEN%20WANT.pdf)
- Howell, L. C. and Beth, A. (2002). Midlife Myths and Realities: Women Reflect on Their Experiences. *Journal of Women & Aging*, 14 (3-4), 189-204. doi: 10.1300/J074v14n03_12
- Hvas, L. (2001). Positive aspects of menopause: a qualitative study. *Maturitas* 39,11-17.
- Hyde, A., Nee, J., Howlett, E., Drennan, J. and Butler, M. (2010). Menopause narratives: The interplay of women's embodied experiences with biomedical discourse. *Qualitative Health Research* 20(6): 805-815.
- Jack, G., Riach, K., Bariola, E., Pitts, M., Schapper, J. and Sarrel, P. (2016). Menopause in the workplace: What employers should be doing. *Maturitas* 85 (2016) 88-95. doi: 10.1016/j.maturitas.2015.12.006
- Jones, E. K., Jurgenson, J. R., Katzenellenbogen, J. M., and Thompson, S. C. (2012). Menopause and the influence of culture: Another gap for indigenous Australian women? *BMC Women's Health*, 12(1), 43. doi: 10.1186/1472-6874-12-43.
- Kelly, B. A. (2011). Menopause as a Social and Cultural Construction. *XULAnexUS (Xavier University of Louisiana's undergraduate research journal)*, 8 (2), 29-39.
- Kittell, L. A., Mansfield, P. K., and Voda, A. M. (1998). Keeping up appearances: The basic social process of the menopausal transition. *Qualitative Health Research*, 8(5), 618-633.

- Kleinman, N.L., Rohrbacker, N.J., Bushmakina A.G., Whiteley, J., Lynch, W.D. and Shah S.N. (2013). Direct and indirect costs of women diagnosed with menopause symptoms. *Journal Occupational Environmental Medicine*, 55(4), 465-70. doi: 10.1097/JOM.0b013e3182820515.
- Koch, P.B., Mansfield, P.K., Thureau, D. and Carey, M. (2005). "Feeling frumpy": The relationships between body image and sexual response changes in midlife women. *Journal of Sex Research*, 42:3, 215-223. doi: 10.1080/00224490509552276
- Kopenhager, T. and Guidozzi, F. (2015). Working women and the menopause. *Climacteric*, 18:3, 372-375.
- Lauzen, M. M., and Dozier, D. M. (2005). Maintaining the double standard: Portrayals of age and gender in popular films. *Sex Roles*, 52(7/8), 437-446.
- Lawton, B.A., Rose, S.B., Stanley, J. and Dowell, A.C. (2008). The menopause symptom profile of Māori and non-Māori women in New Zealand. *Climacteric*, 11, 467-474.
- Leary, M. R. (1995). Social psychology series. Self-presentation: Impression management and interpersonal behavior. Madison, WI, US: *Brown & Benchmark Publishers*.
- Leary, M. R., & Kowalski, R. M. (1990). Impression management: A literature review and two-component model. *Psychological Bulletin*, 107, 34-47
- Lesser, J. G., O'Neill, M.R., Burke, K.W., Scanlon, P., Hollis, K. and Miller, R. (2004). Women Supporting Women: A Mutual Aid Group Fosters New Connections Among Women in Midlife. *Social Work with Groups*, 27 (1), 75-88. doi: 10.1300/J009v27n01_06
- Liamputtong, P. (2013). *Qualitative Research Methods Fourth Edition*. Melbourne, Australia: Oxford University Press.
- Liamputtong, P. (2009). *Qualitative Research Methods Third Edition*. Melbourne, Australia: Oxford University Press.

- Longhurst, R. (2009). Interviews: In-Depth, Semi-Structured. *International Encyclopaedia of Human Geography*, 2009, 580-584. [doi:10.1016/B978-008044910-4.00458-2](https://doi.org/10.1016/B978-008044910-4.00458-2)
- Loseke, D. R. (2011). Andy Lock and Tom Strong, Social Constructionism: Sources and Stirrings in Theory and Practice [Review of Social Constructionism: Sources and Stirrings in Theory and Practice]. *The American Journal of Psychology*, 124(3), 367–370. <http://doi.org.cmeziproxy.chmeds.ac.nz/10.5406/amerjpsyc.124.3.0367>
- Lauzen, M. M. and Dozier, D. M. (2005). Maintaining the Double Standard: Portrayals of Age and Gender in Popular Films. *Sex Roles*, 52 (7/8). doi: 10.1007/s11199-005-3710-1
- Lupton, D. (2012). *Medicine as Culture: Illness, Disease and the Body*. Third Edition. London, England: SAGE Publications.
- Mackey, S. (2007). Women's experience of being well during perimenopause: A phenomenological study. *Contemporary Nurse* (2007) 25: 39-49.
- Mackin, J. (1995). "Women, stress and midlife". *Human Ecology Forum*, 23 (4) p20+. Accessed 20 Jan 2018: <http://link.galegroup.com/apps/doc/A17839343/AONE?u=otago&sid=AONE&xid=1a540c42>
- Mannetje, A., Slater, T., McLean, D., Eng, A., Briar, C. and Douwes, J. (2009). Women's occupational health and safety in New Zealand. *NOHSAC Technical Report 13*, Wellington, 2009. Accessed from: https://cohsr.aut.ac.nz/data/assets/pdf_file/0011/72668/TechRpt13WomensOccHlthSafetyNZ.pdf
- Marnocha, S.K.; Bergstrom, M. and Dempsey, L.F. (2011). The lived experience of perimenopause and menopause. *Contemporary Nurse*, 37 (2), 229-240.

Mitchell, B. A. (1998). Too Close for Comfort? Parental Assessments of "Boomerang Kid" Living Arrangements. *The Canadian Journal of Sociology / Cahiers canadiens de sociologie*, 23 (1) (Winter, 1998), 21-46. Stable URL:
<http://www.jstor.org/stable/3341660>

Matsuzaki, K.; Uemura, H. and Yasui, T. (2014). Associations of menopausal symptoms with job-related stress factors in nurses in Japan. *Maturitas* 79 (2014) 77-85. doi:
10.1016/j.maturitas.2014.06.007

Maturo, A. (2012). Medicalization: Current Concept and Future Directions in a Bionic Society. *Mens Sana Monographs*, 10(1), 122–133. <http://doi.org/10.4103/0973-1229.91587>

Mesmer-Magnus, J. and Glew, D. J. (2012). A meta-analysis of positive humor in the workplace. *Journal of Managerial Psychology*, 27 (2), 155-190. doi: 10.1108/02683941211199554

Midwifery Council of New Zealand, (2014.) Midwifery 2014 Midwifery Workforce Survey. Accessed from:
<https://www.midwiferycouncil.health.nz/images/stories/pdf/Publications/WorkforceSurvey2014.pdf>

Miller, D. (1981). The "sandwich" generation: Adult children of the aging. *Social Work*, 26, 419–423.

Mills, J., Bonner, A. and Francis, K. (2006). Adopting a constructivist approach to grounded theory: Implications for research design. *International Journal of Nursing Practice*, 12: 8–13.
doi: 10.1111/j.1440-172X.2006.00543.x

Misbehaving. (2017). In Oxford English online dictionary. Retrieved from <http://dictionary.oed.com>

Mitchell, B. A. (1998). Too Close for Comfort? Parental Assessments of "Boomerang Kid" Living Arrangements. *The Canadian Journal of Sociology / Cahiers canadiens de sociologie*. 23 (1), 21-46.

- Morris, M. E. and Symonds, A. (2004). "We've been trained to put up with it": real women and the menopause. *Critical Public Health*, 14 (3), 311-323, September 2004. doi: 10.1080/09581590400004436
- Neal, M. B., Chapman, N. J., Ingersoll-Dayton, B. & Emlen, A. C. (1993). *Family Caregiver Applications Series, Volume 3: Balancing work and caregiving for children, adults, and elders* Thousand Oaks, CA: SAGE Publications Ltd. doi: 10.4135/9781483326160
- New Zealand Medical Council (2014). The New Zealand Medical Workforce in 2013 and 2014. Accessed from: <https://www.mcnz.org.nz/assets/News-and-Publications/Workforce-Surveys/2013-2014.pdf>
- Newhart, M. R. (2013). Menopause matters: The implications of menopause research for studies of midlife health. *Health Sociology Review* (2013) 22(4): 365-376.
- Norgate, C. (2012). The Wisdom of Menopause – Creating Physical and Emotional Health and Healing During the Change. Bantam Books, USA.
- North, F. M., and Sharples, K. (2001). Changes in the use of hormone replacement therapy in New Zealand from 1991-1997. *The New Zealand Medical Journal*, 114(1133), 250-253.
- Nosek, M.; Kennedy, H.P. and Gudmundsdottir, M. (2012). Distress During the Menopause Transition. *SAGE Open*, July-September 2012, 2 (3). doi: 10.1177/2158244012455178
- Nosek, M.; Kennedy, H.P. and Gudmundsdottir, M. (2010). Silence, Stigma, and Shame – A Postmodern Analysis of Distress During Menopause. *Advances in Nursing Science*, 33 (3) E24-E36.
- Ohlen, J. and Segesten, K. (1998). The professional identity of the nurse: concept analysis and development. *Journal of Advanced Nursing* 28, 4: 720 – 727.

- Ormston, R.; Spencer, L., Barnard, M. and Snape, D. (2014). The Foundations of Qualitative Research. In Ritchie, J., Lewis, J., McNaughton Nicholls, C. and Ormston, R. (Eds). *Qualitative Research Practice – A guide for social science students and researchers*. 2nd Edition (pp 1-26). London, England: Sage Publications.
- Raup, J. and Myers, J. E. (1989). The empty nest syndrome: Myth or reality? *Journal of Counseling and Development*, 68(2), 180-183.
- Recalcitrant. (2017). In Oxford English online dictionary. Retrieved from <http://www.oed.com/>
- Reynolds, F. (1999). Distress and coping with hot flushes at work: Implications for counsellors in occupational settings. *Counselling Psychology Quarterly*, 12:4, 353 – 361. doi: 10.1080/09515079908254105
- Roush, K. (2011). *What Nurses Know ... Menopause*. New York, NY: Demos Medical Publishing.
- Royal College of Nursing (2016). The Menopause and Work: guidance for RCN representatives. Publication code 005 467. Accessed June 2016 from: <https://www.rcn.org.uk/professional-development/publications/pub-005467>
- Rubinstein, H. (2014). Defining what is normal at menopause: How women's and clinician's different understandings may lead to a lack of provision for those in most need. *Human Fertility*, 17 (3), 218 -222. doi: 10.3109/14647273.2014.929184
- Rubinstein, H. R., and Foster, J. L. (2012). "I don't know whether it is to do with age or to do with hormones and whether it is do with a stage in your life": Making sense of menopause and the body. *Journal of Health Psychology*, 18(2), 292–307. doi:10.1177/1359105312454040

- Rubinstein, R.L., Alexander, B.B., Goodman, M. and Luborsky, M. (1991). Key Relationships of Never Married, Childless Older Women: a Cultural Analysis, *Journal of Gerontology*, 46 (5), 270-277.
<https://doi.org/10.1093/geronj/46.5.S270>
- Sergeant, J. and Rizq, R. (2017). "It's all part of the big CHANGE": a grounded theory study of women's identity during menopause. *Journal of Psychosomatic Obstetrics & Gynecology*, 38 (3), 189-201.
- Setness, P. A. (2000). It's not your mother's menopause. *Postgraduate Medicine*, 108 (3), 11-11. doi: 10.3810/pgm.2000.09.1.1216
- Shildrick, M. (1997). Leaky bodies and boundaries: Feminism, postmodernism and (bio)ethics. London: *Routledge*.
- Shilling, C. (2012). The Body and Social Theory. London: *Sage*.
- Sicurella, E. (2013). Menopause – A Time for Reflection. *Journal of International Women's Studies*, 14 (3). 286-291.
- Simon, J.A. and Reape, K.Z., (2009). Understanding the menopausal experiences of professional women. *Menopause*, 6 (1), 73-76.
doi: 10.1097/gme.0b013e31817b614a
- Simpson, E. E. A. (2016). Chapter 57 – Stress and Coping in the Menopause. (In *Stress: Concepts, Cognition, Emotion, and Behavior*, edited by Fink, G. Academic Press, San Diego).
Handbook of Stress Series Volume 1, 451-455.
<https://doi.org/10.1016/B978-0-12-800951-2.00062-5>
- South Island Workforce Development Hub, 2016. South Island Health Workforce Data – A summary of current health workforce data. Accessed from: <https://www.sialliance.health.nz/our-priorities/workforce-development-hub/useful-resources/>
- State Services Commission, (2016). Worker Wellness Information and Resources. Wellington, 2016. Accessed from: <http://ssc.govt.nz/sites/all/files/worker-wellness-resource-kit.pdf>

- Statistics New Zealand, (2013). Census Data and Reports. Retrieved from: <https://www.stats.govt.nz/topics/census>
- Statistics New Zealand, (2008). Births and Deaths: December 2008 Quarter. Accessed from: http://archive.stats.govt.nz/browse_for_stats/population/births/BirthsAndDeaths_HOTPDec08qtr/Commentary.aspx
- Stephens, C., and Breheny, M. (2008). Menopause and the virtuous woman: The importance of the moral order in accounting for medical decision making. *Health*, 12 (1), 7–24.
- Stephens, C. (2001). Women's Experience at the Time of Menopause: Accounting for Biological, Cultural and Psychological Embodiment. *Journal of Health Psychology*, 6(6), 651-663.
- Stephens, M.A., Townsend, A.L., Martire, L.M. and Druley, J.A. (2001). Balancing parent care with other roles: Inter-role conflict of adult daughter caregivers. *Journal of Gerontology*, 56, 24–34.
- Stotland, N. L. (2002). Menopause: Social expectations, women's realities*. *Archives of Women's Mental Health*, 5, 5–8.
- Strauss, J. R. (2011). The Baby Boomers Meet Menopause: Fertility, Attractiveness, and Affective Response to the Menopausal Transition. *Sex Roles*, 68, 77-90. doi: 10.1007/s11199-011-0002-9
- The American Congress of Obstetricians and Gynaecologists, (2011). 2011 Women's Health Stats & Facts. Washington, United States. Accessed from: <https://www.acog.org/-/media/NewsRoom/MediaKit.pdf>
- The North American Menopause Society, (2015). Non-hormonal management of menopause-associated vasomotor symptoms: 2015 position statement of the North American Menopause Society. *Menopause: The Journal of the North American Menopause Society*, 22 (11), 1-18. Accessed from: <http://www.menopause.org/docs/default-source/professional/pap-pdf-meno-d-15-00241-minus-trim-cme.pdf>

- The North American Menopause Society, (2012). The 2012 Hormone Therapy Position Statement of The North American Menopause Society. *Menopause: The Journal of The North American Menopause Society*, 19 (3), 257-271. doi: 10.1097/gme.0b013e31824b970a
- The Nursing Council of New Zealand (2015). Nursing The New Zealand Nursing Workforce – A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2014 - 2015. Accessed from: <http://www.nursingcouncil.org.nz/Publications/Reports>
- Twaddle, S. and Khan, M. (2014) Health and Disability Kaiāwhina Worker Workforce – 2013 Profile. Berl Economics, 2014. Accessed from: <https://www.careerforce.org.nz/wordpress/wp-content/uploads/2013-Health-and-Disability-Kaiawhina-Worker-Workforce-Profile.pdf>
- Uehli, K., Mehta, A. J., Miedinger, D., Hug, K., Schindler, C., Holsboer-Trachsler, E., Leuppi, J. D., and Künzli, N. (2014). Sleep problems and work injuries: A systematic review and meta-analysis. *Sleep Medicine Reviews*, 18 (1) 61-73. <https://doi.org/10.1016/j.smrv.2013.01.004>
- Unison, (2016a). Menopause and Work. Accessed August 2016: <https://www.unison.org.uk/content/uploads/2013/06/On-line-Catalogue204723.pdf>
- Unison, (2016b). Menopause Factsheet. Accessed August 2016: <https://www.unison.org.uk/content/uploads/2013/08/Briefings-and-CircularsMenopause-Factsheet3.pdf>
- Ussher, J. M. (2008). Reclaiming Embodiment within Critical Psychology: A Material-Discursive Analysis of the Menopausal Body. *Social and Personality Psychology Compass*, 2 (5), 1781-1798. doi: 10.1111/j.1751-9004.2008.00151.x
- Utz, R.L. (2011). Like mother, (not) like daughter: The social construction of menopause and aging. *Journal of Aging Studies*, 25, 143-154. doi: 10.1016/j.jaging.2010.08.019

- Van Gorp, K. (2013). The Second Shift: Why Is It Diminishing but Still an Issue. *A Journal of Undergraduate Student Research* 14. <http://fisherpub.sjfc.edu/ur/vol14/iss1/7>
- Villar, F. (2012). Successful ageing and development: the contribution of generativity in older age. *Ageing and Society*, 32, 1087-1105. doi: 10.1017/ S0144686X11000973
- Warrick, P. (1994). Feminists face off in the war over Menopause. *Los Angeles Times*, August 9, 1994. Accessed from: http://articles.latimes.com/1994-08-09/news/ls-25315_1_menopausal-women
- Wilson, R. A. (1964). The Obsolete Menopause (Guest Editorial). *Delaware Medical Journal*, January 1964. Accessed from: <http://menopausemoxie.com/wp-content/uploads/2014/09/The-Obsolete-Menopause.-Wilson-1964.pdf>
- Wilson, R.A. and Wilson, T.A. (1963). The Fate of the Non Treated Post-menopausal Woman: A Plea for the Maintenance of Adequate Estrogen from Puberty to the Grave. Accessed June 2016 from: <http://menopausemoxie.com/wp-content/uploads/2014/06/The-Fate-of-the-Untreated-Menopausal-Woman.-Wilson-1963.pdf>
- Winterich, J. A. (2003). Sex, Menopause, and Culture – Sexual Orientation and the Meaning of Menopause for Women's Sex Lives. *Gender & Society*, 17 (4), 627-642. doi: 10.1177/0891243203253962
- Writing Group for the Women's Health Initiative Investigators, (2002). Risks and benefits of estrogen plus progestin in healthy menopausal women. Principal results from the Women's Health Initiative randomized controlled trial. *JAMA*, 288, 321-333. Accessed from: <http://jama.jamanetwork.com/article.aspx?articleid=195120>

Appendices

Appendix A – Information Sheet for Participants

Reference Number: *D16/216*



Experiencing Menopause

The experience of menopause for women working in health

INFORMATION SHEET FOR

PARTICIPANTS

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the Aim of the Project?

The aim of the project is to explore the experience of menopause for women working in health. In New Zealand there has been little research on women's experience of menopause in general, or in the workplace specifically. This project is being undertaken as part of the requirements for Kathryn Goodyear's Master of Public Health.

What Types of Participants are being sought?

We want to interview 12 female nurses at Christchurch Hospital between the age of 45 and 55 years who are perimenopausal or menopausal. If you choose to participate you will be provided with a \$30 voucher in recognition of your contribution to the research. A copy of the main findings of the research will be made available to you if you wish to receive this.

What will Participants be asked to do?

Should you agree to take part in this project, you will be asked to

- Attend a face to face interview at a time and location agreeable to you.
- It is expected that the interview will take no longer than an hour

The interview will be audio-recorded. You can end the interview at any time if you feel uncomfortable with the line of questioning. Your participation is entirely voluntary (your choice). Please be aware that you may decide not to take part in the project without any disadvantage to yourself.

What Data or Information will be collected and what use will be made of it?

We will ask your ethnicity and age and record your gender as this may be important when we analyse the interviews. We will transcribe the interview and remove your name and any identifying material from the transcript. Only the research team will have access to your information. The data collected will be securely stored in such a way that only those mentioned below will be able to gain access to it. Data obtained as a result of the research will be retained for **at least 5 years** in secure storage. Any personal information held on the participants may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.

The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity.

You may decide to withdraw from the study anytime until 31 March 2017. If you do so, the information you provided will be destroyed immediately.

This project involves an open-questioning technique. The general line of questioning includes how female health workers experience menopause in the workplace. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. Consequently, although the Department of Population Health is aware of the general areas to be explored in the interview, the Committee has not been able to review the precise questions to be used.

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s).

Can Participants change their mind and withdraw from the project?

You may withdraw from participation in the project at any time up until 31 March 2017 without any disadvantage to yourself.

What if Participants have any Questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:-

Kathryn Goodyear

and Association Professor Gillian Abel

Department of Population Health

Department of Population Health

University Telephone Number:

University Telephone Number:

Tel 64 3 364 3602

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This study has been approved by the Department stated above. However, if you have any concerns about the ethical conduct of the research you may contact the University of Otago Human Ethics Committee through the Human Ethics Committee Administrator (Ph 03 479-8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

Appendix B – Consent Form



Experiencing Menopause **The experience of menopause for women working in health** **CONSENT FORM FOR** **PARTICIPANTS**

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time before 31 March 2017 without any disadvantage;
3. Personal identifying information [*e.g. audio-tapes*] will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least five years;
4. This project involves an open-questioning technique. The general line of questioning includes how female health workers experience menopause in the workplace. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops and that in the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.
5. I understand I will receive a \$30 voucher to thank me for my participation.
6. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity.

I agree to take part in this project.

.....

(Signature of participant)

.....

(Date)

.....

(Printed name)

Appendix C – Interview Questions

Experiencing Menopause

The experience of menopause for women working in health

Key areas to explore

- Awareness/understanding of menopause
 - What do you understand by the term ‘menopause’?
 - When were you first aware that you were menopausal, what did that mean for you?
- Experience of menopause at work
 - Can you tell me about your experience of being a menopausal women in your workplace?
 - Explore meanings, feelings, understanding, and visible signs/symptoms
 - What has been the impact on your work – how do you manage this?
 - Disclosure of menopausal status
 - Extent of discussion with colleagues about this, talk to anyone else?
 - Is there anything else that may also be impacting on your work?
 - Explore competing demands on time and energy
- Work environment
 - How well does your work environment support you?
 - Is there anything you would change about your workplace?
 - What would make a difference for you?
- Sharing with others
 - What advice would you give to other nurses in the same situation?

